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ORIGINAL ARTICLES

CYSTIC DEGENERATION OF THE OVARIES AS A CAUSE OF DYSMENORRHEA.*

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Dysmenorrhea as defined by Dorland is painful or difficult menstruation, and is divided into congestive; inflammatory; mechanical or obstructive (membranous); and spasmodic. Billings gives the different forms as congestive, endometric or inflammatory; intermediate or intermenstrual; mechanical, due to some obstruction to the flow; membranous, in which a membranous substance is passed with menstrual fluid; neuralgic; ovarian; tubal, depending upon narrowness or obstruction of fallopian tubes; and uterine.

To the careful student many of these terms do not clearly state the condition as found in the operating room. Unless a very large incision through the vagina or an abdominal section has been made, a diagnosis of cystic ovary is impossible, except, of course, in very thin subjects and when the cysts are quite large.

While many cases of dysmenorrhea present a variety of signs and symptoms, the ovarian pain in the vast majority of cases is a prominent symptom. So conspicuously has it been shown in many cases that have come under the observation of the writer, that he has opened the abdomen for no other reason than to relieve these symptoms by division of adhesions or by the resection of one or both ovaries.

Before proceeding further let us first decide what these cysts are. What do they contain, and of what are their walls formed? And what is their pathology? Doran declares that ovarian pain is due to sclero-cystic and cirrhotic ovary, the latter being the final stage of the former, and that both are due to inflammation, which is rarely uncomplicated, as cirrhosis without peritonitis has not come under his observation.

Herman says he has treated these so-called ovarian pains by resec-

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tion and by removal of both ovaries, and the results have been singularly uniform—the immediate results were pleasing—the patients left the hospital delighted, but after a few weeks or months they have returned as bad as ever, except the reflex pain due to dysmenorrhea. His meaning here is somewhat ambiguous, as he does not say what prompted the operative procedures, but admits that the reflex pain of dysmenorrhea remained absent.

Jessett ascribes the pain to cystic ovaries or the ovary with the thick fibrous capsule which, according to the teaching of some, is the same disease in different stages of inflammation.

Coblitz, Marchand, Olshausen, Schroeder, and others are silent on the subject of cystic and scirrhous ovary as a cause of dysmenorrhea and only speak of the condition as being a factor in the etiology of carcinomatous transformation.

There is no doubt in the mind of the writer that these so-called cysts are nothing more than Graafian follicles in different stages of degeneration. The inflammatory condition, irrespective of its pathogenesis, so toughens the enveloping capsule that the normal rupture of the follicle does not take place, and as a consequence of its retention, degeneration of surrounding tissues takes place on account of the pressure.

Since the writer has been doing abdominal surgery his attention has been arrested by the macroscopic appearance of ovaries in cases in which the abdomen has been opened for whatever purpose.

At first he was content with puncturing cysts with a needle or bistoury, but he is now convinced that in order to destroy these cysts, a resection is the better operation.

The ignipuncture of some operators has never appealed to the writer, and the puncture and the pulling out of the lining membrane as practiced by Cannady, of Virginia, does not seem to be an operation of exactness, for the reason that the cyst wall is apt to tear and is not thoroughly removed.

The better plan is to slit the ovary down to the hilus and remove the edges of the incision with the scissors, going to the full depth of the cyst, or scrape it out with the sharp curette or knife blade. The organ, if necessary, can be cut away to the hilus and still enough of it be left to perform its function. This, to the mind of the writer, is the true conservation of the ovary, and from experience he can state that while the results have not been uniformly good, still out of thirty-three cases of which records were kept, eighteen were entirely relieved of the dysmenorrhea; five improved, and ten were no better.

In these cases here enumerated, at least half were what are denominated neurasthenics, and were in a poor physical condition at the time of the operation.

When we take into consideration the length of time many of these poor dysmenorrheic women suffer—is it not to be wondered at that

many of them live and do not eventually land in some of the state hospitals for the insane?

It must not be understood from the foregoing that all cases of dysmenorrhea are ovarian in origin, but rather let it be understood that the purpose of this paper is to draw attention to cystic degeneration and cirrhosis of the ovary as a frequent cause of dysmenorrhea that cannot be remedied by topical applications and tonics. If attempts are made along these lines, anodynes will eventually be resorted to with the result of hopeless invalids in which no operation will relieve.

In the study of each individual case of ovarian dysmenorrhea it must be presupposed that a previous ovaritis, simple or complicated, preceded the cystic degeneration.

In the operating room they are more frequently found accompanying displacements of the uterus; in ovaries that are pendulous, and in the cases due to interfered circulation; and in cases of former pelvic peritonitis, as is evidenced by the more or less strong bands of adhesion found on opening the abdomen.

26 Linmar Bldg.

DISCUSSION.

D. C. Lester Hall, Kansas City: I wish to endorse fully what the doctor has said in regard to ovarian dysmenorrhea. I am in a position to know, from a fairly large experience that ovarian dysmenorrhea does exists, and that these small follicular cysts give rise to more trouble in women, more actual pain, than the large glandular cysts, which reallly give very little trouble until they begin to produce pressure symptoms. It is the practice of all operating gynecologists of recent years to do just as the doctor says he does, and the result is verified in the great majority of cases, as the doctor found, with perfect relief of the patient. I think we do not always get this immediate relief following operation, but in the course of a few months, pains will disappear at the menstrual period, whereas before the patient suffered not only at the menstrual period but intermenstrual periods, from retention of the follicles. There is no topical or constitutional treatment that will relieve this condition, but the marvellous results that follow such resection as the doctor has described, which does not entirely impair the function of the ovary, are most gratifying. In fact, the woman seems to functionate as well after the operation as before. The operation is a rebuke to those men who formerly, and some to-day, for slight cystic degeneration of the ovary, removed the entire ovary. I agree with everything the doctor says, and I want to commend it most heartily to those men who are in the habit of removing these ovaries for slight cystic degeneration; also to those who leave every patient without operative procedure.

Dr. J. D. Griffith, Kansas City: I was exceedingly interested

in Dr. Dorsett's valuable paper. I think it comes home not only to St. Louis men and Kansas City men, but to every one of us. We see these cases of dysmenorrhea, and whenever a mother brings her daughter into my office, at fourteen or fifteen years of age, when she is just beginning to have menstruation, attended or unattended with leucorrhea, absolutely the picture of health in every other way, I shudder; that is the way I feel. I feel like I wish I had never heard of medicine. It brings up the question, what would you want done if this was your own daughter. If there is no cystic degeneration of the ovaries will not the condition of this uterus with this dysmenorrhea, bring about a cystic degeneration; that is what I mean. In other words, this child, this young girl, has been active in exercise, and has probably thrown the uterus a little backward, or she has been subject to constipation, and with the straining, etc., the ligaments have been pulled upon and relaxed enough so that the uterus has fallen backward, and when she commences to menstruate, you have dysmenorrhea, painful menstruation. You cannot make a satisfactory examination of the child. You do not feel like doing it. You do not want to do it. The mother shrinks from it; the child will shrink from it; you shrink from it. The best you can do is to make a rectal examination. That is all you can do. Here is the uterus, and it has probably leaned a little too far back. You know that after a while interference with the circulation is going to lead to some trouble with those ovaries, that there is going to be hypertrophy, on account of the interference with circulation, and you are going to have cystic degeneration. What are you going to do with these cases? You cannot propose an operation at once. Every doctor in this room that has had any experience has had these cases. What are you going to do with them? Leave them alone, and you are almost sure that they will go on from bad to worse. You don't see them get well, and the woman comes to the time when she is engaged and going to be married, and she is still a sufferer. You have given whatever you chose, viburnum or whatever you chose. It is all the same. They will come back to you month after month. You go to work and try to correct the position of this uterus. Can you do it? You cannot put on the Smith lever with any satisfaction to yourself. You feel like you are absolutely helpless. Let me tell you, this inquiry of Dr. Dorsett's is one that needs to be answered, and I don't know how you are going to do it. I shall be very grateful if some one will give us a remedy for these cases that the doctor is talking about.

Dr. E. F. Robinson, of Kansas City: There is one point which seems to me very important in the consideration of this paper, and that is the question of hysteria. All these patients, or at least a great proportion of them, are hysterical patients. Does then the hysteria cause the symptoms, or vice versa? I cannot but believe

that among the great faults that exist today in modern surgery are some of the operations on our hysterical women. It is very, very common to find every woman who is hysterical believing that she has something wrong with her ovaries, and when she once gets that idea in her head, sometimes even a surgical operation will not remove it for very long. Unquestionably these women have taught us a tremendous amount of surgery, but when we get back to the ultimate fact, are they very much better? I believe that we should be extremely careful of our diagnoses in these cases, excluding as nearly as possible the element of hysteria, knowing the pathological condition before we operate, even, if necessary, giving the patient an anesthetic, avoiding the giving of any more attention than is possible to the ovary in these nervous hysterical women. Conservatism is the word along this line, and certainly it is better to leave a portion of the ovary than to remove it all. Only two weeks ago, I had a note from a patient from whom a pus-tube was removed and a diseased ovary on one side, and a portion of the ovary left on the other side with this tube. That woman today is the happy mother of a very healthy child. Conservatism, then, I would say, and careful diagnosis, avoiding the point of hysteria, and then as much surgery as is necessary, because too much surgery, I certainly believe, is bad surgery.

Dr. H. E. Pearse, Kansas City: I believe the doctor is right in looking beyond the cystic ovary in his survey of the field. I don't think anything in these cases will take the place of the clean surgical operation described by Dr. Dorsett, in which the diseased area is removed. That is a settled surgical fact, and is brought out not by thirty years but in my case by twenty years' practice,—which is about the life of the present surgical and gynecological era. It takes a double view to make pathology, both inside and outside. There is an element here which we must not forget, there is womanhood to treat, as well as the woman. I have found two things in my practice that have helped me with these young girls, where I wish to keep them from the knife, and where the tissues were so soft and disease so recent that there was hope of a cure. The first is in the attention to the breathing capacity of the patient and the application of the rules laid down by Harris of Chicago for the measurement of the abdomen, to see to it that the waist line is in proportion to the length of the trunk. These nineteen and twenty inch waists won't give you breathing space enough. You must remember that the abdomen is a cylinder. A wide waist and a flexible abdomen, with deep abdominal breathing, will give you circulatory relief in these cases, and this means freedom from the so-called inflammatory changes in the ovary, which are not infected inflammation, but errors of development and nutrition. Secondly, as far as medicine is concerned, there are two that will do good. I will mention them,

and the literature and investigations of the past thirty years will help you to apply them: the first is the nitrite of soda, and the other is a proper administration of thyroid gland extract and the extract of other ductless glands in the body, by the use of which you will attract to the ovary that degree of nutrition which will help it.

Dr. Dorsett, in closing: I was somewhat gratified to hear Dr. Griffith say what he did, because his experience was so nearly along the lines that I have travelled, in this matter of knowing what to do for these girls. But the paper dealt more particularly with the after effect of inflammation. It is what the inflammation has produced that we are now considering, and not simply an ovaritis pure and simple, or an ovaritis due to a pelvic peritonitis, but simply the condition left after the acute inflammation. I do not believe that any gentleman would treat a case of cirrhotic ovary that had been inflamed a good while ago, in which pathological changes had taken place, as in the case I have described, by topical application; and tonics do no good. You have simply a condition left that has to be relieved, just as we have adhesions sometimes following any pathological condition that we afterwards have to open the abdomen to relieve.

Now, as to whether these cases are hysterical or neurasthenic; I said in these cases here enumerated that at least half of them were denominated neurasthenics, and were in a poor physical condition at the time of the operation. I did not mean for you to infer that the eighteen that were so much benefited from the operation were neurasthenics, but that there were neurasthenics in the thirty-three cases.

The paper drew attention to ovarian dysmenorrhea, and not any other kind of dysmenorrhea. It was cystic degeneration for which I operate, and not for a symptomatic trouble around about the neck of the uterus, as suggested by one of the speakers.

THE SURGICAL TREATMENT OF GLAUCOMA.*

BY JAMES MOORES BALL, M. D., OF ST. LOUIS.

Glaucoma has been defined as increased intraocular pressure plus the causes and results of such pressure. It is a disease which, if untreated, invariably tends to produce blindness.

The causes and pathology of the affection are beyond the scope of this paper. I shall not consider secondary glaucoma, such as follows the growth of intraocular tumors, or a neglected iritis, but will limit the paper to the varieties of idiopathic glaucoma.

The operative measures to be considered may be divided into ocular and extraocular ones; the former class is represented by numerous operations in which the eyeball is attacked, while the latter comprises only the excision of the cervical portion of the sympathetic nerve.

I.—*Ocular Operations for Glaucoma.* From among numerous procedures I will select for your consideration only the following: 1. Iridectomy; 2. Hancock's operation, and 3. Sclerotomy.

1. *Iridectomy.* Up to date iridectomy remains the best and most useful surgical procedure in the treatment of glaucoma. It is applicable to all forms of idiopathic glaucoma, although it is of greatest utility in the acute inflammatory type. It is a valuable procedure in glaucoma simplex, and even in hemorrhagic glaucoma it is capable of giving good results as is shown by Oliver's series of eight cases. Schweigger collected 28 eyes with hemorrhagic glaucoma, of which all went blind and 24 ended in enucleation. Of Oliver's eight cases, iridectomy saved useful vision for three cases for eight, six, and four years respectively; in two cases the disease was held in check for several months.

As regards the usefulness of iridectomy in the various types of glaucoma, Wygodski's statistics are of interest. In an analysis of 458 cases he found that the immediate results were favorable in all cases of the inflammatory type; favorable in 49 per cent. of chronic cases; and also in 90 per cent. of cases of glaucoma simplex. Two or more years after operation he found of 37 cases of acute inflammatory glaucoma 76 per cent. remained improved; 5 per cent. were unchanged; 11 per cent. had deteriorated and 8 per cent. had become blind. Of 147 cases of chronic inflammatory glaucoma, 10 per cent. showed improvement; 40 per cent. were no worse; 30 per cent. had deteriorated; and 20 per cent. were blind. Of 129 cases of simple glaucoma, 1 case remained improved; 16 per cent. continued stationary; 48 per cent. had grown worse; and 35 per cent. were entirely blind. As Jackson

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remarks, such statistics do not fully show the value of iridectomy, because many of the cases which continued to grow worse after iridectomy grew worse more slowly, and without operation there certainly would have been none that improved and but few that remained stationary.

It is evident that iridectomy is of less value in glaucoma simplex than in the acute inflammatory and the chronic inflammatory types.

I have always felt that in many cases of glaucoma simplex the prolonged use of miotics resulted in the loss of valuable time, and that such medical treatment not infrequently resulted in blindness in some cases, which, if given the benefit of an iridectomy at an early date, would retain useful vision. For many years I have performed iridectomy on practically all cases of glaucoma simplex that have come under my care, and fully 60 per cent. of these cases have retained useful vision. I am pleased to know that Berry, of Edinburgh, stands with me in this matter. At the meeting of the ophthalmic section of the British Medical Association in 1904, he came out strongly in favor of iridectomy in glaucoma simplex. In the discussion of Berry's paper, Uhthoff said that in his cases of glaucoma simplex 5 per cent. improved after iridectomy; in 45 per cent. the disease remained stationary; in 40 per cent. the disease advanced slowly in spite of operation, and in 10 per cent. the vision grew much worse.

Although iridectomy gives the best results if done early, before vision is much reduced, yet at times astonishing improvement occurs in cases which are apparently hopeless. A case in point is as follows: Mrs. J. F. D., aged 51 years, was brought to me on September 27, 1905. Vision had failed rapidly for four weeks. She has had "neuralgia" in the face and eyes for the same period. Atropine had been used by her medical attendant. When I first saw her, vision in each eye was reduced to perception of light. The globes were hard, the pupils dilated widely, and the corneæ looked steamy. Regardless of the unfavorable outlook, I made a broad iridectomy temporally on each eye, hoping the patient would gain enough vision to enable her to dispense with the services of a guide. The after-treatment was simple, the eyes were dressed daily and a solution of adrenalin chloride was instilled. The improvement in this case was progressive and astonishing. On January 25, 1906, she returned for glasses. The vision of each eye without glasses was 15-200. With glasses:

R. E. with plus 4.50=15-50; L. E. with plus 3.50 combined with plus 1.00 axis 90°=15-35. With stronger lenses she was able to read the ordinary magazine type.

A point which I wish to emphasize about iridectomy for glaucoma is that the operation should be made always under a general anesthetic. The pain is such, and the difficulties attending the making of a technically correct glaucoma iridectomy are so great, that the use of a local anesthetic alone is not justifiable in this disease. I have

always employed a general anesthetic, preferaby chloroform. I am sure that some of my confreres who have operated under local anesthesia have troubled consciences.

In performing the operation the keratome should be introduced 1 to 2 mm. behind the corneo-scleral junction. Your books will tell you to remove a large piece of the iris. I have found by experience that the size of the piece to be removed is of much less importance than is the site of the incision.

2. *Hancock's Operation.* Many years ago Hancock, a London surgeon, acting on the erroneous theory that glaucoma is due to spasm of the ciliary muscle, producing stasis of the intraocular circulation, proposed and often practiced the operation which bears his name. It is a cyclicotomy or sectioning of the ciliary muscle. The operation is not described in any of the modern text-books except my own. It is made by passing a Beer knife with its cutting edge outward into the corneo-scleral junction, extending the incision into the sclera for one-fourth of an inch. Thus the following structures are cut: the periphery of the cornea, the periphery of the iris, the ciliary body and the sclera. Immediately the aqueous humor escapes and a bead of the vitreous humor appears in the wound. Pollak, the pioneer oculist of St. Louis, saw this operation performed by its originator. He practiced this procedure for forty years and said of its use in glaucoma: "A few seconds only are required for this operation. The relief from increased tension and pain is instantaneous. The lens recedes to its normal position, the pressure upon the ciliary processes is removed, the iris being freed from pressure soon resumes its normal place, the spaces of Fontana are gradually opened, and so also is the canal of Schlemm."

As regards Hancock's operation, I am convinced that it has a distinct place in the treatment of glaucoma. The following case will show its usefulness. Mrs. Mary Harris, aged 54 years, was seen by me in consultation on July 14, 1906. Six weeks ago she became suddenly blind. She was not treated for one week. Then Dr. G.——, a general practitioner, was called who used atropine twice a day. When I first saw her, vision was limited to perception of light and the tension of each eye was plus 3. The same day under chloroform I made an iridectomy on each eye. Two days later the tension of the right eye was plus 2, while that of the left eye was about normal. The following day I made Hancock's operation on the right eye. Result, Mrs. H. can read with the right eye; the vision of the left eye has not improved.

In absolute glaucoma, where pain makes the patient's life a burden, it is considered good surgery to remove the offending organ. In a number of such cases I have succeeded in avoiding this mutilation by performing Hancock's operation.

3. *Sclerotomy.* This operation was introduced by Quaglino in

1871, for the reason that some leading ophthalmic surgeons believed that the beneficial effects of iridectomy were due, not to the excision of a piece of the iris but to the incision in the sclera. A sclerotomy may be anterior to the iris or posterior to this structure. A few ophthalmic surgeons prefer sclerotomy to every other kind of surgical intervention in glaucoma. De Wecker was an advocate of anterior sclerotomy which he performed in a peculiar manner. Among the French oculists of today, Abadie is opposed to the operation, while Dianoux uses it in every form of glaucoma. Posterior sclerotomy was advocated by William Mackenzie, of Glasgow, in 1830. Without wearying you with the various modifications of what is really a very simple operation, I will say that my experience with sclerotomy has not been favorable. I sometimes make a posterior sclerotomy a few days before performing iridectomy, in cases where the execution of the latter operation is almost impossible on account of the practical obliteration of the anterior chamber. Here a sclerotomy causes the chamber to be restored and thus enables the surgeon to make an iridectomy under favorable conditions.

It is only fair to state, however, that Lawson who has had a large experience in London, considers sclerotomy a valuable operation in the following conditions:

1. In cases of glaucoma in which a well-performed iridectomy has failed to reduce the tension.
2. In glaucoma occurring in aphakic eyes.
3. In hemorrhagic glaucoma.
4. In glaucoma occurring in eyes with a high degree of myopia. because of the liability of intraocular hemorrhage in such eyes.

As regards the dangers of these ocular operations for glaucoma I will say only a word. Given a skillful operator and the proper anesthesia (chloroform or ether for iridectomy; cocain for Hancock's operation and for sclerotomy), there are two dangers: infection and hemorrhage. Up to date I have never had an iridectomy, sclerotomy or Hancock operation infected. I have lost one eye from chorioidal hemorrhage which appeared within a few minutes after the completion of an iridectomy.

II.—*Extraocular Operation for Glaucoma.* Excision of the Superior Cervical Sympathetic Ganglion for Glaucoma. Eight years ago I reported to this society for first excision of the sympathetic made on this side of the Atlantic for the relief of glaucoma. A somewhat extensive experience with this operation, and the leveling influence of time, have served to place this procedure in the class of "last resorts." The operation is immediately followed by remarkable improvement in vision, but unfortunately this improvement does not last in a large percentage of cases. With few exceptions, this operation has not had a fair trial for the reason that the cases in which it has been employed have been desperate ones—cases in which iridectomy

and sclerotomy have proved unavailing. Furthermore, there is good reason for the belief that to obtain the best results it is necessary to remove both superior cervical ganglia, the sympathetic of the one side being connected with the other side by the ganglion of Ribes.

At the present time sympatheticectomy is advocated by a number of competent ophthalmologists. It is the general opinion that it is of greater value in glaucoma simplex than in the other types of this disease. However, further observations will be necessary before the proper place can be assigned to this operation.

4500 Olive Street.

DISCUSSION.

Dr. John Green, Jr., St. Louis: There is one point in connection with Dr. Ball's paper to which I should like to allude, namely, that he seems to regard the use of miotics in glaucoma simplex as of no value. I believe all ophthalmic surgeons are agreed on the inefficacy of miotic treatment in any type of inflammatory glaucoma, the operation of choice being a broad peripheral iridectomy. I am quite certain, however, that iridectomy is not imperatively indicated in all cases of glaucoma simplex. At the last meeting of the American Medical Association, Dr. William C. Posey, of Philadelphia, read an interesting paper entitled "The Treatment of Glaucoma Simplex with Miotics." Dr. Posey is a man of wide experience, and his work with miotics in glaucoma simplex covers many years. He found that the persistent use of miotics, such as eserin and pilocarpin, did retard the progressive loss of vision, and, to a large extent, the contraction of the visual field also. It is absolutely essential that, if the miotic treatment is undertaken, the patient should understand the necessity of continuous, thrice daily instillation of pilocarpin solution, associated with at least a single application daily, of eserin solution. In my own experience, I know of cases of glaucoma simplex that have been carried along ten or fifteen years by the miotic treatment alone. A patient of 60 years of age had been carried up to her death at 73, under the miotic treatment alone, and at the end she was able to read her Bible.

Furthermore, we must not forget the statistics that Dr. Ball presented with reference to the final outcome of iridectomy in glaucoma simplex. As I understand, Dr. Ball agreed with Wygodski, whose statistics show that after the lapse of two or more years iridectomy in glaucoma simplex had permanently benefited only 1 out of 125 cases. Furthermore, the operation of iridectomy in glaucoma simplex is occasionally followed by rapid deterioration in vision, where the deterioration prior to the operation had been slow. Taking all these things into consideration, it seems to me that we should hesitate before undertaking a procedure in glaucoma simplex which may do vastly more harm than the intelligent, persistent, continuous treatment by miotics.

Dr. Ball spoke of using adrenalin chloride after an iridectomy which he did for acute glaucoma. I believe that such a procedure is contraindicated. We have recently had reports of a very peculiar action from adrenalin chloride in glaucomatous eyes. For instance, a case was reported a few years ago in which adrenalin chloride provoked an acute glaucomatous condition in an eye which had previously been in a condition of non-inflammatory glaucoma. It seems to me irrational to run the risk of provoking a further attack of glaucoma by using this agent.

Dr. Llewellyn Williamson, of St. Louis: I would like to ask Dr. Ball to elaborate a little more fully his statement that the extent of the iridectomy was immaterial, but that the site of the iridectomy was the important point. It seems to me that the extent of the iridectomy is very material, not in width but in depth. I believe an iridectomy for glaucoma, to be efficacious, must be a deep one reaching well into the root of the iris.

Dr. Ball in closing: The question of the best treatment for glaucoma simplex has been under debate for many years, and I do not look for it to be settled this afternoon. Every man is entitled to his own opinion, based on his own observation, provided he gives due respect to the opinions of his equals and of his superiors. I have seen a few cases in which there was rapid deterioration of vision in glaucoma simplex after iridectomy. The difficulty attending the miotic treatment is this: that very few patients will carry out faithfully the instructions outlined by the ophthalmic surgeon. Time and again, I have had patients brought to me blind from glaucoma simplex who had been subjected to the treatment with miotics, such as eserin and pilocarpin.

The gentleman who opened the discussion undoubtedly is entitled to his opinion, and he has good reasons perhaps for that opinion, but I stand by the proposition as outlined in the paper.

As regards the question by Dr. Williamson, I mean this—the amount of iris to be excised. Suppose, for example, we say 1-6 or 1-5 of the iris; the excision of that much of the iris in some cases I have found to be technically impossible, without traumatism which would produce cataract, or produce a tearing of the periphery of the iris; and time and again, I have seen those cases in which only a small portion of the iris was removed, but that small portion running far back to the periphery, I have seen those giving excellent results. So that this matter of the 1-5 or 1-6 of the iris to be removed is not nearly so important as the point at which your keratome is to be introduced.

THE TREATMENT OF LOBAR PNEUMONIA.*

BY ORVILLE HARRY BROWN, MT. VERNON, MO.

The mortality from pneumonia is very high. There are no specific remedies for the disease. The treatment must of necessity be symptomatic. To outline a rational symptomatic treatment, requires a familiarity, first, with the pathologic conditions causing the symptoms, and second, with the physiologic action of the drugs which may ameliorate the symptoms. It is with the two latter points that this paper deals.

Most likely the heart conditions demand the closest attention. The obstructed lungs are interfering with the passage of the blood from the right to the left heart, and hence the pulmonary blood-pressure is high, and the right ventricle is required to do more than its usual amount of work, and is very apt to become dilated. The toxemia causes an increased temperature and dilatation of the arterioles, and hence, a low arterial tension and frequent pulsation of the heart. The low aortic tension causes a lessened coronary circulation, and hence a poorly nourished heart. The unusual pulmonary and arterial tensions and the badly nourished heart, are liable to cause an arythymia of the heart. The drug which is now used most frequently to counteract the heart conditions is digitalis. This agent causes the heart beat to be less frequent, inhibits the dilatation of the heart, facilitates the flow of the blood through the lungs and produces a higher aortic tension by causing a constriction of the arterioles. The higher aortic blood-pressure causes a better blood supply to the heart. Strophanthus has essentially the same action as digitalis. Strychnine produces only a constriction of the arterioles. Caffein and atropine cause practically the same results on the circulation as strychnine. Saline infusions fill the vessels and increase the blood-pressure, and dilute the viscid and toxemic blood.

Nitroglycerin and the drugs which produce a fall of the blood-pressure are plainly contraindicated. It may be possible, in case of an acute dilatation of the right ventricle, that good would result by a marked dilatation of the peripheral vessels,—thus lessening the amount of the blood going to the right heart. Bleeding may do good under the same condition as when nitroglycerin is of benefit. Alcohol is now held not to be indicated in pneumonia.

The fever in pneumonia is perhaps best dealt with by the cold fresh air treatment, which consists in keeping the patient in the open air, even though the climatic conditions are unpleasant. As well as reducing the temperature the air has its full proportion of oxygen,

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and hence is much more preferable for the patient than a vitiated atmosphere. The reduced breathing area of the lungs might be compensated for by arranging for the patient an atmosphere with a content of oxygen considerably higher than that of air. But this should be used early and regularly throughout the course of the disease. The toxin is manufactured in the lungs, and is forced into the blood by the respiratory movements. The faster and deeper the breathing, the greater the toxemia is likely to be. Fresh air with its full or an excessively high content of oxygen, would be indicated also from this course of reasoning.

An elimination of the toxin is best stimulated by a regular taking of alkaline waters, liquid diet, and saline infusions.

The toxemic condition of the blood renders it acid, and it has been proven that an animal stands oxygen deprivation better if its cells are bathed in an alkaline medium. Sodium bicarbonate will keep up the alkalinity of the blood.

The coagulability of the blood in pneumonia is much greater than normally, and hence the fibrin content of the blood is high and the viscosity is likewise high,—this tends to make a sluggish flow of the blood through the vessels. Sodium citrate lengthens the coagulation time of the blood. It should be given hypodermically as it is slowly absorbed from the alimentary canal. Sodium citrate is split in the blood into the carbonates which have an alkaline reaction. Hence the citrate of sodium has the triple effect of reducing the coaguability, the acidity and the viscosity of the blood.

The pain in pneumonia may be handled by strapping the side, by giving opium, or by other well understood methods.

Before concluding, a word might be said of the reported excellent results from the empirical use of quinine and iron in pneumonia. Suffice it to say that the reports speak in glowing terms of uniform good results from this method. The patient is given a large initial dose of quinine—50 to 70 gr.—and it is repeated at a later stage if it seems necessary. The administration of the tincture of the chloride of iron is soon begun and is continued during convalescence. It is claimed that this procedure will much reduce the severity of the attack if it does not abort the attack entirely.

By way of summary let it be said that by long odds the one organ which is, above all others, to be carefully watched, is the heart. And after a careful study, first of the conditions influencing the heart, and second of the physiologic action of the remedies which might be thought to be of value, it seems that digitalis comes the nearest to properly sustaining the heart in a typical case. Saline injections,—rectal, hypodermatic or intravenous,—are plainly indicated as additional support to the heart and for diluting the toxin-ladened blood. In the cases without tendency for dilatation of the ventricle, strychnine would be more indicated than digitalis. The cold fresh air and the

quinine and iron, in view of the reported good results, may be employed. The treatment of other symptoms than those mentioned need not be discussed further as the opinions concerning them are not so varied. Concerning the preparations of the drugs and their dosage, it is best to use, when feasable active principles in small dosage at sufficiently frequent intervals to get the desired physiologic effects.

DISCUSSION.

Dr. A. B. Cole, Sedalia: The most rational thing that has come into the practice of medicine has undoubtedly been the open air treatment of pneumonia. This is worth more than all we ever knew before and it is a shame that there are yet doctors in the State of Missouri who know this and who have not the backbone to say to their patients that they must do this or that. I know of two cases the treatment of which I lost last winter and I know of one of my fellow practitioners losing a case, because the people did not want a physician who treated pneumonia with an ice bag and the open air treatment. It is a sensible thing because the lung is a double chamber for furnishing certain forces to the body and you cannot carry a man through a distressing attack of pneumonia and permit him to breathe poisoned air. It makes very little difference about the temperature of the air just so it is fresh outdoor air.

Dr. Robert T. Sloan, Kansas City: Like the gentleman who has just spoken, I believe that one of the great advances in the treatment of this disease has been in the administration of an abundance of fresh air, but I cannot subscribe to the process of refrigeration. I don't believe it is necessary that a patient be put in a roof garden or a tree in order to get fresh air, but I do believe in plenty of ventilation. I understood the doctor to repudiate the use of alcohol in the treatment of pneumonia. I emphatically protest against alcohol being laid on the shelf in the treatment of pneumonia. With the exception of opium I believe alcohol is the one drug in the treatment of this disease, which is the greatest slaughterer of all the infectious diseases. It is a beautiful thing, in theory, to speak of the effect of the consolidation of the lung upon the right heart and the accentuation of the pulmonic sound, and it is beautiful to hear how it diminishes day after day, indicative of failure of the ventricle, but as a matter of fact the patient is full of rales which, in the labored breathing, will often entirely obscure the nature of the heart sounds, and you must depend upon the appearance of the patient and the character and rate of the pulse in making your prognosis. It has been possibly my peculiar experience that with but one exception all the cases of double lobar pneumonia I have treated have recovered. That certainly does not support the idea that the amount of lung involved cuts any great figure in the mortality. It is the toxemia that kills and not the obstruction to the flow of blood through

the lung. In one patient the area of involvement may be but half the size of the hand, yet that patient dies, while another may have two-thirds of the lung involved and survive. Furthermore, when the temperature has dropped and the patient is in a refreshing sleep and on the road to recovery, there is practically the same consolidation in the lung as before the crisis. What is the cause of the increased strength of the hearts's action? It is the formation of an immunity, the toxemia has been relieved; it is not due to the fact that the heart is no longer obstructed in its action as a pump. Digitalis has been recognized as the ideal therapeutic agent in keeping up the heart's action but I confess I was somewhat staggered when somebody recorded 1,200 cases of pneumonia with a mortality of 3 per cent., the patients having been treated by enormous doses of digitalis leaves. Personally I believe the digitalis treatment is wrong. I don't believe every case of pneumonia should receive alcohol, but when the heart begins to fail, when there is congestion and the appearance of extreme debility, then alcohol should be used, but not as it is ordinarily used. A tablespoonful of brandy every three or four hours? No, give an ounce of brandy to begin with and if this does not have the desired effect, give two ounces; and if still no improvement, give three or four ounces every two hours until you do get the improvement. Under that administration of alcohol I have seen a number of recoveries among patients who, from the examination of the heart, seemed doomed.

Dr. J. M. Allen, Liberty: I do not think pneumonia is such a fatal disease as many consider it. I agree that fresh air is indispensable but I don't agree with the application of cold. I am sure I have saved a few cases by blood letting and maybe I have lost a few, possible lost more than I saved. Twenty years ago I quit both blood letting and the use of whiskey and I rarely lose a case of pneumonia. Now, what is the condition in pneumonia? Half the blood in the body goes through the lung and with every air cell closed and many of the bronchi closed, there is a great decrease in the amount of oxygen that can go into the lung. Therefore, you want more fresh air. Now what is the effect of the alcohol upon the lung? Does it not increase the very thing you want to decrease? Another thing, why give a remedy whose effect is transient? Its effect only lasts forty or fifty minutes and you must keep repeating the dose. You can use another remedy, such as digitalis or strychnine and the effect lasts from four to six hours. Why not use that? The cause of death is the toxemia to some extent. In regard to the heart, I say emphatically that it does increase the action of the right side of the heart very greatly. A solid lung does cut off the blood supply and then for want of oxygen the true toxic condition increases very rapidly. Here is where comes in the value of your heart stimulants and strophanthus has a specific action on the right side

of the heart. You can have a dilatation of the heart in half a day. The moment the muscle begins to relax, just that moment the dilatation begins. There the great remedy is strophanthus in conjunction with digitalis, strychnine and nitroglycerine. There is no tonic to the brain like opium and there is no shock to a man like the beginning of this disease. My first treatment is to give a man opium and calomel and I keep him more or less under the influence of the opium, not to the point of narcotism, giving 1-10 to 1-15 grain of morphine at a dose. Then I saturate the patient with salicylate of soda for twenty-four to thirty-six hours, lessening the severity of the disease very greatly. Then it is a question of endurance, it is a question of how much oxygen you can get in there and how long you can keep the heart pumping. In no disease do I feel that I can bring to bear all the forces of therapeutics as effectively as I do in pneumonia.

Dr. E. H. Miller, Liberty: Such discussions as these put the younger practitioner at sea without a rudder. I am satisfied that there are many men of two, four or five year's practice who have listened to our learned friend Dr. Allen, and to my friend Dr. Moore, whom they have learned to lean upon, and to Dr. Sloan, knowing him deep in pathological lore. Think what effect such a discussion as this has upon the young man. But there is one ray of hope, and that is that therapeutics and pathology are often poor guides in the treatment of many of our diseases. When I returned from New York after a course of study under Loomis I am sure I had in my note book some remedy that would reach each of the various stages of the disease, but in the presence of first epidemic practical experience wiped out all that Dr. Loomis had told me. I had some very fatal cases until I was sickened with the treatment of pneumonia. Then I was called in consultation and met a young man who knew but little about pathology and therapeutics, yet his success had been phenomenal. But finally in one case he sent for me. I asked him what he did for his patients and he said: "I keep the windows open and treat the conditions as they come up. I treat each one individually, but I always give each one plenty of fresh air and plenty of water." Now if some young man would ask me, "to what do you consider your success in pneumonia due?" I would hate to say, "I don't know." When I listen and find but a tiny spot involved and see the patient going down the toboggan I say to myself, what is killing him? I cannot conscientiously say why certain patients die and why others recover, but I do adhere to one thing, I try to keep the pump going. I saw a patient last winter with blue fingernails, pinched features and I gave him oxygen and he drank it like a thirsty child and got well. I can see how you can help a man along with it, yet I cannot see why one gets well and another dies. If there is any one thing in the world that our young

men must do in the treatment of pneumonia, it is that each must pull his own load.

Dr. P. C. Scholz, St. Louis: These men do not disagree in their method of treatment. It does look that way on the surface but it is not really true. One question of importance is, where are you located and who applies your remedies—if such they be. Those who are close observers of the conditions in which digitalis and its relations are given, give these remedies with flattering results. If you do give digitalis and expect success you must give it in large doses. Again, where do you practice? Have you a competent nurse, or have you a nurse at all? The advocates of digitalis are located where they have competent assistants and these are enthusiasts on digitalis. Those who must depend upon a mother or feeble grandmother as a nurse have many failures. The application of the remedy depends upon the circumstances under which it is applied. You can rely upon your friend strychnine but be careful about your alcoholics and administer alcohol early and persistently. In on ailment is the observance of and attention to throat, mouth and nose of greater importance.

Dr. Brown in closing: The symptomatic treatment of any disease is always a debatable question, and the treatment of pneumonia, which is as yet wholly symptomatic, is perhaps more debated at the present time than that of any other disease. The two factors of the disease which must necessarily be considered are the mechanical obstructions to the circulation, and the toxemia; in some cases one of these conditions, and in some the other, predominates. We may have a case in which the toxemia is not very deleterious, but in which a large portion of both lungs is involved, thus, obstructing the flow of the blood from the right heart to the left and hence overloading the right heart. On the other hand we may have a case in which only a small area of the lungs is involved, but in which the toxemia weakens the heart action by interfering with the oxidative processes in the blood and also by causing a dilatation of the arterioles, and hence a low arterial tension. Since the blood supply of the heart comes from the aorta it is of extreme importance that the aortic blood pressure be kept as near a normal tension as possible. Digitalis, strophanthus and strychnine are undoubtedly the three best drugs for this purpose. Preference is usually given to these drugs in the order named. Alcohol does not raise the blood pressure except temporarily, but rather has a tendency to lower it and hence is contraindicated.

As a final word it must be said that since no two cases are alike it is impossible to lay down a rule which will hold for every case. You must study your cases and treat each one according to the conditions found.

POSTURE IN LABOR.*

BY W. B. DEFFENBAUGH, M. D., ST. JOSEPH, MO.

For indulging in the ghoulish business of resurrecting this subject, I trust that you will pardon me. While I know this subject has been settled in the minds of most gentlemen present, and in practice a routine method is followed which gives satisfactory results to the attending physician, candidly couldn't the results, so far as the mother is concerned, occasionally be improved upon?

This attitude of contentment on the part of the physician is justified by the oracles of obstetrics, "The Wise Men of the East," who write most of our excellent text books on the subject, for in the majority of them the subject receives scarcely more than a passing mention. 'Tis true that in operative work and in difficult cases, the proper positions are indicated, but wouldn't it be better to speak more fully on the subject.

From a not inconsiderable experience in the practice of obstetrics and observation of the customs of other physicians, I know that most labors in this country are conducted with the woman flat on her back, with thighs flexed on the abdomen and legs on the thighs. The best that can be said of the position is, it might be worse. For with the woman in this position until such time as a firm engagement of the presenting part occurs, the promontory of the sacrum causes the uterus to assume one or the other of the lateral positions, usually the right, in which position the direction of the uterine force is not in the line of the pelvic outlet, and therefore expulsive force is wasted.

Would it not be better to have this woman occupy a position in which the body was on an incline, say of 45 degrees, and thereby conserve force, and get the benefit of the weight of the child's body in dilating the parts below? This, for tardy labors.

Again, after a firm engagement of the presenting part, with the woman lying on her back, the weight of the child is largely thrown on the spinal nerve supply of the rectum and this causes an extra expulsive effort on the part of the woman, and, if she has a justo-major pelvis, a possibly precipitate labor, and torn perineum with the untoward after effects may result. If that woman was turned on her side with hips elevated, expulsive efforts would be more easily under voluntary control, and more ready assistance could be given in the preservation of the perineum, and a tear much less apt to occur. This, for precipitate labors.

In the order of frequency following tardy and precipitate labors, some abnormal position of the child demanding turning, is per-

*Read at the Fiftieth Annual Meeting of the Missouri State Medical Association, Jefferson City, May, 1907.

haps the next most common condition demanding assistance. The contra-indications to turning are tetanic contraction of the uterus, and the impaction of the child in the pelvis. The first condition cannot be overcome by position, but the latter may, and for the relief of this condition several positions are available. For the relief of the impaction, the knee-chest position is probably the most favorable, but it has as drawbacks, uncomfortableness to the patient, and furthermore it is a position that cannot be maintained by the patient, when an anesthetic is given; and again most efforts at turning can be but imperfectly performed with the patient in this position. The lateroprone position, with the hips elevated, is a posture more favorable for the success of turning and offers nearly as good results in overcoming impaction, and relaxation may be assisted by an anesthetic, if needed, in this position. In merit, it stands midway between the knee-chest and modified Trendelenberg positions. The Trendelenberg position, with the body on the incline, with the head low and buttocks elevated, with legs hanging over the elevated end of the table, is a wonderful help in abdomino-pelvic operations, but on account of their tenseness the abdominal muscles interfere with external manipulations, and as the patient lies on the back, the perineum cannot be pushed back; there is therefore but little room for the introduction of a hand in combined versions. The limbs, too, occupying a line on a plane with the upper axis of the pelvis, interfere with the lateral motions sometimes needed.

I must think, therefore, that the Trendelenberg position has but a limited field of usefulness in obstetrics proper. If, however, you will modify the position by putting the patient in the Trendelenberg position, then flex the thighs upon the abdomen, you have an ideal position for the relief of impaction and for relaxation of the abdominal muscles, and at the same time you increase the diameter of the outlet and get the limbs out of the way.

In impaction, pelvic in character, either of these postures will be of assistance in overcoming the condition but I must give a preference for the modified Trendelenberg.

In the reposition of a prolapsed cord, either of the positions are available, but as you may wish to use the forceps, at the time of replacing the cord, it is easy to let your patient down from the Trendelenberg into the lithotomy position which is the most convenient for most of us in the use of forceps.

In cases in which the child's head will not engage, and yet in which there is but a slight disproportion between the head and the superior strait, the Walcher position, with the woman drawn with the buttocks flush with the edge of the table and limbs and feet unsupported, gives from 1 to 1½ cm. in the upper strait and may be the means of causing an engagement.

Here, we have in addition to the increase of space, increase of

muscular tension and therefore intra-abdominal pressure, both factors in causing the engagement. In the high application of forceps, this position is most favorable to their successful use.

Finally, in a relatively large proportion of cases, when labor is slow from either a relative or actual large size of the foetal head, or from a rigidity of the maternal soft parts, the bony outlet is increased by a strong flexion of the thighs upon the abdomen and the labor is terminated more quickly by this position, but this increase in the bony pelvis is not often needed, the muscles are not affected by the position, but the skin is rendered much more tense and therefore liable to tear, and when a tear is started in the skin it easily extends to and into the muscles.

It is true that we may have a subcutaneous rupture of a muscle, but such occurrences are relatively infrequent, in comparison with tears which begin in or with the skin and extend into or through muscle.

As a protection against tears of the perineum, when they seem imminent, an extension of the thighs will frequently prevent them.

In conclusion, permit me to summarize as follows:

1st. In the average case of labor, the woman will do well, in any posture.

2nd. In tardy labors, due to inefficient uterine contractions, the woman will do best who most nearly assumes the upright posture.

3rd. In precipitate labors, the converse is true, and the elevation of the hips, with the patient on her side, is the best posture.

4th. In impaction, that position which by gravity helps to overcome the condition and lessens the field of operation, the abdomen relapsed and in the best attitude for bi-manual work, is best and for this we have the modified Trendelenberg posture.

5th. When engagement does not take place, and yet the disproportion between the presenting part and the diameter of the superior strait is not too great, or in any condition in which we wish to increase the diameter of the superior strait, we would have recourse to the hanging or Walcher posture.

6th. When from a relative disproportion between the size of the presenting part and the vulvar outlet, or when on account of a rigidity of the perineum, we fear a tear, we would recommend an extended or modified Walcher posture.

SOME INJURIES OF JOINTS.

BY W. A. SHELTON, M. D., KANSAS CITY, MO.

In the strenuous life of the average American of today, this unfortunate condition is so frequently met with, that it behooves the surgeon to familiarize himself with some of the salient points in injuries of joints. Still another reason for the renewal of this old subject is the fact that fully sixty per cent. of all mal-practice suits have their beginning in results, bad or otherwise, arising from a dislocated hip-joint, a fractured knee cap, etc. In short, there is no class of injuries which a surgeon approaches with more doubt and misgivings, or one which demands a greater amount of ready knowledge, self-reliance and skill. Constant in their occurrence, and often extremely difficult of diagnosis and management, they frequently involve consequences hardly less serious to the surgeon than to the patient himself. I certainly know of no subject which requires a more thorough knowledge of topographical anatomy, a nicer sense of discrimination, a calmer judgment, a more enlarged experience, or a greater share of vigilance and attention; in a word, none which demands a higher combination of surgical tact and power. As for myself, I never treat such a case however simple, without a feeling of deepest anxiety in regard to its ultimate issue. Hence the importance of the subject is at once appreciated by all of us.

The joints, although well arranged to resist violence, none the less, as parts of the body in which mobility is greatest, naturally form weak points in the economy. As this is a very extensive subject, it shall be the purpose of this paper merely to mention a few of the injuries of joints, and to dwell more fully on fracture—dislocations of the upper extremity. Simple contusions of joints are often seen, as are also sprains, and it is sometimes very difficult to distinguish between sprains and dislocation. The special importance of these injuries lies however in their relation to the various constitutional diatheses, wherein a very slight injury may lead to most serious results. Tuberculous disease of the joints is a striking example which dates from an injury often marked by insignificant immediate results.

Shoulder Joint. Injuries to this joint occur almost as frequently as all other joint injuries combined (about 50 per cent.) The articulation between the head of the humerus and the glenoid cavity of the scapula surpasses every other joint in the body in freedom of range and variety of movement. The shallowness of the cavity, the size of the head, the laxity of the capsule and the want of direct support of the structure at its lower and inner part, and the fact that the

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movement of abduction of the humerus is normally checked mainly by tension of the capsular ligament, all explain the great frequency of this accident. In this, as in all other joints, the all important feature in dislocation lies in injury to the capsule. The location and size of the rent often determine the direction taken by the displaced humerus, and again, a small rent may make the reduction a very difficult procedure. Sometimes the capsule is not torn, its laxity allowing the head to slip below the cavity at least one inch. Besides injury to the capsule, varying degrees of laceration may occur in the structures surrounding; such as ecchymosis of the skin (more marked when injury is due to direct violence), rupture of artery or vein, which may be followed by gangrene of the limb, thrombosis or death from internal hemorrhage, and occasionally we have fracture of the bones themselves. Nerves usually escape injury.

In dislocation of the shoulder, the head of the humerus naturally takes one of four directions: (1) Upward, (2) Downward. (3) Backward. (4) Forward. The first is very rare, if it ever occurs. The second is more frequent, and the head of the humerus rests in the upper part of the axillary border of the scapula, on the long head of the triceps, which is sometimes lacerated. The deltoid is very tense, and both tuberosities may be fractured. Usually there is injury to the circumflex nerve and axillary artery. In the third variety, the head of the humerus usually rests back of the acromion, or below the spinous process of scapula. In the fourth, which is by far the most common, the head is just under the coracoid process. In this position it is above the tendon of the subscapularis, which is either torn or stretched over the neck as a tense band and may hinder reduction. The short head of the biceps and the coraco-brachialis cross the inner part of the head. The long head of the biceps usually remains in its groove. The axillary vessels and nerves are seldom injured, but are pushed forward and inward between the subscapularis and pectoralis major. Sometimes the head may pass further internally, and rest on the second rib and serratus magnus under the clavicle. This condition is usually accompanied by more severe muscular and ligamentous injuries than the other varieties, especially in rupture of muscles surrounding the capsule, separation of the great tuberosity, and displacement of the long head of the biceps. The phenomena seen in such a dislocation is best illustrated in the case of Mr. J. Aet. 40. Carpenter. Engaged in a fight, March 24, 1907. I saw him ten hours after injury, and after two unsuccessful attempts at reduction without an anesthetic had been made. The left shoulder was badly swollen and very painful, and depressed. A yard stick placed on the outside of the humerus was made to touch both the acromion and the outer condyle at the same time. It was well nigh impossible to make the elbow touch the chest wall when the left hand was placed over the right nipple. Measurement around the right shoulder was

seventeen inches, around left, eighteen inches. The anterior and posterior axillary folds were lowered, and the cavity shallowed. The head of the humerus could be felt just internal to the coracoid process, but not distinctly. With slight force, I could rotate the humerus internally to a small degree, and the limb seemed more movable than is usual in such cases. I anesthetized the patient, and proceeded to reduce the dislocation, which appeared to be what some authors call the subclavicular variety. As for the methods of reduction, the books describe quite a number, such as Kocher's, Smith's, Cooper's, etc., which are all good no doubt, but the main thing in all reductions is to first relieve the tension on the surrounding structures, by an anesthetic, and the rest is comparatively easy. After complete anesthesia, and the assistant immobilizing the scapula, extend the arm, elevate it, and at the same time making traction, manipulate the head with the other hand, and then quickly lower, internal rotate, and place hand on opposite shoulder. In this variety, with these movements the tense posterior part of capsule will pull the head in to the glenoid cavity. I usually place the arm in the same position as I would for a fracture of the outer part of clavicle, keeping it in this position for two or three weeks, giving the surrounding parts a complete rest and a chance to return to a normal condition.

In the case of Mr. J., I was called to see him some five or six hours after I had followed this procedure. He was in severe pain, and the bandage was so tight I had to remove it. I saturated absorbent cotton with a hot lead and opium solution, and afterwards placed on a large amount of cotton batting to retain the heat. When I first examined him, I found that ecchymosis had extended to elbow and all over shoulder and pectoral region. Numbness was in fingers showing injury to median nerve. With constant application of the lead and opium solution, for about five days, the swelling and pain gradually subsided, and I again placed the arm in the position outlined by velpeau. I removed the dressing at the end of the second week, and placed the arm in a sling. At this time I noticed a flaccidity of the deltoid, and an apparent looseness of the joint, with inability to raise the arm at right angles, and to rotate it outwards. On grasping the humerus, and rotating it, I thought I detected a slight crepitus.

From the fact that he was unable to lift the arm at right angles, or to turn in outwards, I thought possibly the great tuberosity was fractured, so I advised x ray. Dr. MacCandless took one exposure which plainly explained the trouble, as the great tubercle was seen detached from the upper part of the bone, causing a loss of action of the teres minor, supraspinatus, and infraspinatus muscles. I placed a small pad under the axilla, and a heavy pasteboard cap over head of humerus, and held the same tight by adhesive straps; after three weeks I began passive motion, and now he has fairly good use of his arm.

Elbow Joint. Fracture—dislocations of this joint form a subject of very deep interest, not only on account of their frequency, but because of their great liability to serious complications, and the consequent difficulty of their diagnosis and treatment. The diagnosis of such injuries is often difficult from the amount of swelling that quickly follows. Hence a good rule is to use the x ray whenever obtainable. Dislocation of both bones may occur backwards, forwards, or laterally. The frequency, is in the order just named. There is always great deformity at the elbow, and the forearm is generally in a partly flexed and pronated position. Sometimes the joint is absolutely immovable, probably due to the position of the coronoid process in the olecranon fossa. At the posterior part of the joint is the unnatural projection formed by the olecranon, and in front are the prominent condyles of the humerus. The distance between the elbow and wrist is diminished (probably an inch), in front, but behind the limb retains its normal length. When the humerus is fractured just above the condyles, the deformity closely resembles that produced by a dislocation backwards, the lower fragments with radius and ulna being drawn in that direction. In dislocation the parts are fixed and cannot be restored without considerable force; whereas, in fracture they are easily moved and replaced, returning however, to their unnatural situation the moment the efforts are discontinued.

Fracture of the olecranon can always be distinguished by the elevation of the upper fragment, and the gap which separates it from the lower, and by the ease with which the surgeon can bend the arm.

Always compare the other arm, especially the elbow. In an extended position, the outer and inner condyles and the tip of the olecranon are in a horizontal line to the axis of the humerus. The head of the radius is just beneath a slight dimple on the posterior part of the elbow below the external condyle. These are points to always bear in mind in dealing with any injury of the elbow-joint. In the backward variety, the elbow is slightly flexed, and the diameter of the arm above the joint is increased. The condyles, more especially the inner, may be separated. Promation and supination, and flexion to a right angle, may be made; but practically no extension is possible. Forward dislocation is exceedingly rare, and probably never occurs without fracture of the olecranon. In outward dislocations, the forearm is slightly flexed, the radius usually strongly pronated; and when the limb hangs by the side, the forearm is seen to be abducted and the internal condyle is very prominent. Sometimes the ulna is displaced backward, and the radius forward (divergent), which usually causes slight flexion, and the forearm is half way between pronation and supination. When inward dislocation occurs the elbow is still slightly flexed, and pronated; abduction of the forearm is present and the outer condyle is prominent.

In the divergent variety the whole limb appears to be shortened, manipulation very rigid, and flexion very slight, if at all.

Case I. J. P. Aet. 37. Was scuffling, and sustained injury to right elbow. April 20, 1907. He claimed he had twice before had the same joint injured. When I saw him, the elbow was badly swollen, and crepitus, of the "grinding" variety, was heard. In the swollen condition, I could not make out any thing definite, although I suspected the condyle was detached. I could reflex and extend the forearm, but it caused him much pain. I placed the arm in a temporary right-angled pasteboard splint, and the next day had an x ray taken with the following disclosures.

The plate showed a line of probable fracture, beginning at the apex of coranoid process, and extending for one-half inch in a line parallel with the curve of the sigmoid cavity, thence downwards, separating the sigmoid cavity and the olecranon from the ulna. On the humerus, there is an apparent fracture completely through the epiphyseal line, separating the condyles and articular surface of humerus, but on examining the second plate prominence of internal condyle was found absent, and a circular shadow was seen below, plainly showing its displacement downwards, caused by contraction of the superficial flexor muscles of forearm, and the pronator radii teres. A dim line was seen showing the head of radius, above this the shadow of olecranon was shown, which did not completely fill the olecranon fossa. As I could feel no distinct prominence of the olecranon at the back of the joint, to gain apposition of the epicondyle I placed the arm in a flexed position, using the heavy pasteboard splint. After three weeks I removed the splint, and began passive motion, the patient carrying the arm in a sling. The results are satisfactory.

Case II. I. G., Aet. 9. This case was referred to me Aug. 19, 1907, by Dr. S. E. Wells. I did not see him for some time after the injury occurred, and do not remember now how it was caused. Two views were made by Dr. McCandless. The first was taken from before backwards, showing only a separation at the epiphyseal line, without being able to determine any displacement; marked interference at the extreme end of the olecranon process, where the tendon of the triceps is attached just below, was observed. This might have been easily overlooked in this direction, because of the combined density of the condyle and the end of the olecranon; in the second plate the typical epiphyseal fracture was seen, with dislocation of the distal fragment forward. Here there was no combined density to obscure the sequestra loosened by the triceps tendon. I placed a small pad in turn of arm over the condyles, and then put the limb in a light plaster-of-Paris cast, placed left hand over right shoulder, and then a bandage according to Velpeau, completely immobilizing the arm.

The third plate showed the line of apposition obtained by the flexed position.

September 19. I anesthetized the patient and slowly extended the arm to break up adhesions. He is improving rapidly and carrying a slight weight.

CHRONIC SUPPURATIVE OTITIS MEDIA.*

BY G. E. GWINN, M. D., SPRINGFIELD, MO.

The parts involved primarily and most frequently are the Eustachian tube and tympanic cavity, with the membrana tympani. Later in the disease the attic space, the upper part of the drum-cavity beneath the tegmen tympani may be affected, and finally the mastoid aditus, antrum and pneumatic cells may be involved in the suppurative process in order named.

There is a group of cases in which the chronic suppuration is limited at first to the attic space, with, perhaps, some involvement of the aditus and autrum, the artrum or lower part of the drum-cavity, being free from suppuration and showing a tendency to remain free. These cases are not numerous, but they form a most important class, as they are most invariably attended with necrosis in the head and neck of the malleus and incus. They lead to disease in the mastoid autrum, with risk of further mastoid disease, if not relieved before the necrosis advances backward toward the mastoid, or attacks the neighboring walls of the autro-tympanic space.

Any cause productive of an acute suppurative otitis media is competent to produce chronic otitis media. The most common causes assigned are coryza and the exanthemata, especially measles and scarlet fever, the latter being the most frequent assigned cause. Teething, diphtheria and typhoid fever are sometimes assigned causes of chronic otorrhea, and la grippe leaves with us many discharging ears. It is found in scrofulous, lymphatic, arthutic, hepatic tuberculous and syphilitic disease, and is generally associated with naso-pharyngeal catarrh.

On looking over literature of suppurative otitis media one is impressed with the number of different plans of treatment recommended, and the great variety of medicinal agents in the success of which their respective advocates seem to have implicit confidence, that many cases of chronic suppuration, even of long duration, are cured by these so-called conservative methods is well known to all.

That many cases have been treated by such methods for a long period of time and still continue to discharge, is equally well known. The great majority of cases found in the latter class undoubtedly accounts for the belief found both among the laity and physicians, that little or nothing can be done for discharging ears.

When a patient with a chronic suppurating ear applies for treatment the first question to decide is not what remedy to use, but whether this is a case for conservative or surgical treatment.

As our diagnostic ability increases our reputations will suffer less

*Read before the Harrison Coun ty Medical Society.

from unsuccessful attempts to cure surgical cases by non-surgical means. In the present state of our knowledge it is not always possible to determine at the first examination in which class a given case belongs.

The pathological conditions which nature cannot be expected to correct without the help of the surgeon may be enumerated as follows:

1st. Bone necrosis, either in the ossicles, attic, antrum or mastoid.

2nd. Granulations or polypi within the deeper cavities of the middle ear.

3rd. Osteosclerosis of the mastoid.

4th. lining of the deeper cavities of the middle ear with epidermus, either with or without cholesteatoma.

Sometimes only one of these conditions is present; again all may be found in a single case. Sometimes the surgical cause of the suppuration is easy and sometimes difficult of recognition. When a surgical cause of the continued suppuration cannot be discovered it is perfectly proper to treat the case conservatively until it is cured or until it becomes apparent that there is some condition present which will require radical measures.

The treatment of chronic suppurative otitis media may be classified as:

1st. Mechanical, including attempts at cleansing and drainage of the cavities of the middle ear.

2nd. The use of medicinal agents supposed to have germicidal or healing properties.

3rd. The use of internal remedies, either for building up the general health of the patient or for their more direct effect upon the suppurative process.

4th. The surgical treatment, which includes the removal of granulations or polypi from the auditory canal and middle ear, enlarging the perforation to secure better drainage, ossiculectomy, the removal of the plate of bone between the attic and the inner end of the auditory canal, and the radical or tympano-mastoid operation.

As distinguished from the ordinary mastoid operation, the tympano-mastoid operation includes not only a clearing away of all diseased tissue within the mastoid process, but the removal of the posterior and superior wall of the auditory canal, removal of the drum membrane, malleus and incus, together with the outer wall of the attic. This turns the mastoid, mastoid antrum, attic middle ear and auditory canal into one cavity, which is expected to become lined with skin.

Where to undertake the tympano-mastoid operation for the relief of chronic suppuration is a question which must be settled upon its merits in each individual case, but as a rule such an operation should be resorted to in all cases, which cannot be cured by radical measures. As exceptions to this rule may be mentioned those suffering from well

advanced pulmonary or other organic disease, and the very aged who have had suppurative otitis media for a long time without apparent inconvenience.

In addition to the continued discharge after other plans of treatment have been thoroughly tried, persistent odor is a special symptom pointing toward the necessity of radical operation. Odor means decomposition, and decomposition means accumulation, and accumulation means failure in the efforts to drain or di-infect the deeper parts of the middle ear.

Pain in the ear in the mastoid, or in the side of the head may be slight or severe, may be continuous or intermittent. When present it points toward the necessity of an operation, but the absence of pain is by no means an indication that a radical operation may not be required. The same may be said of temperature, although it is the rule for patients with chronic suppuration, especially with odor, to have slight elevation of temperature at some time or other during every twenty-four hours.

Tenderness upon pressure over the mastoid as a symptom is unreliable, since it is found when the mastoid is not diseased and may be absent when the entire mastoid is necrotic, leaving only the outer table in tact.

However, as a general indication, tenderness on pressure, when taken with other symptoms, points toward surgery. When auscultation of the mastoid by means of the stethoscope and tuning fork, shows any change in the normal density of the bone it is additional evidence of the necessity of operation.

The discovery of necrotic bone in the mastoid or deeper parts of the middle ear is a positive indication for the operation. When the perforation is of sufficient size necrotic bone may be searched for with a probe, or the washings from the ear may be filtered and the debris examined with the microscope for bone cells. When the discharge is slight and evidence of necrosis is found in the ossicles the ossicles may be removed.

The prognosis in such cases is fair, but unless great care is used in the selection of cases for ossiculectomy they will either not be cured or will later submit to a more radical operation.

There is as great danger from a chronic discharging ear as there is from an appendix in which there is pus formation, but too many of the profession do not as yet recognize this fact. Many an individual with such a discharging ear walks the streets or goes about his daily work, who, could he know the danger, would seek his physician.

Macewen calls attention to the fact that such a patient may work at the severest labor up to the very hour of the rupture of an attic abscess.

P. Hammond reports three cases of chronic suppurative otitis to demonstrate the necessity for prompt checking of suppurative process

in the ear. It is not enough that the external discharge of the ear has ceased, as it is possible for the disease to remain latent for years. There must be absolute cessation of crust formation before the ear can be considered safe.

A careful study of cases of long continued suppuration will frequently show diseased bone as a cause of the chronicity. After some experience with the fine silver probes used for this purpose it is astonishing how often we will be enabled to detect the presence of caries of the ossicles, and even to tell with considerable precision its exact location.

J. C. Beck reports a number of cases in which he has experimented with radium. In some cases of suppuration, both before and after operation, repeated exposures to radium rays might have improved the conditions, but the author has been unable to formulate any rules for its application or to foretell with any degree of certainty the result of treatment.

It is rare to have chronic abscesses of the middle ear without more or less complete closure of the Eustachian tube. If this tube is open the abscess will be constantly drained and areated, which condition would of itself tend to produce a cure even without other treatment. The direction of the Eustachian tube is inward, downward and forward, when the body is erect. Consequently if there is an occlusion anywhere along its course the contained pus will be bottled up and only so much of it will escape as can force its way through the drum membrane above the level of the upper portion of the tube. Therefore the absess can never drain itself completely, but a certain amount of stagnant pus will always be present undergoing putrefactive changes with all its evil consequences.

Syringing the ear as ordinarily practiced for purulent otitis does not cleanse the middle ear and rarely reaches the Eustachian tube. Consequently its value is extremely limited. Syringing the ear may bring about an infection of the mastoid cells, the very thing we most fear and most desire to avoid.

Chronic purulent otitis media is almost always accompanied by a salpingitis of the Eustachian tube, and unless this receives proper recognition it will be impossible to cure the otitis, as it will continue to act as a constant and ever present source of infection for the middle ear.

To maintain an aseptic or antiseptic condition it is imperative that there shall be good and sufficient drainage. This can only be obtained by having the Eustachian tube thoroughly dilated and the opening in the drum membrane as large as possible.

Dilatation of the Eustacihan tube may be accomplished by any one of the following methods, preference being given to the order in which they are mentioned:

1st. By forcing air into it through the Eustachian catheter by

means of Politzer's air bag, not less than twelve or fifteen insufflations should be given at a sitting.

2nd. By forcing air into it through the Eustachian catheter at a pressure not to exceed twenty-five pounds. The air may be medicated by interposing a vaporizer between the catheter and compressed air tank. For this purpose there is nothing better than iodine. The dilatation should be continued uninterruptedly for a period from five to fifteen minutes

3rd. By means of insufflation with Politzer's air bag and a suitable nose piece without the interposition of the catheter. To obtain the best results the patient should be made to swallow water simultaneously with the compression of the air bag. This tends to open the Eustachian tube and shuts off the passages forward and backward. Twelve or fifteen inflations should be given at each sitting.

There are still other methods such as Valsalva's and the Eustachian bougie, etc., which I will not take time to explain, as the ones already given are the best for dilating the Eustachian tube and bringing about desired results.

THE SURGICAL TREATMENT OF DISEASES OF THE GALL BLADDER AND ITS DUCTS.*

BY J. DEVOINE GUYOT, M. D., JEFFERSON CITY, MO.

There is no region of the human body where surgical treatment is so clearly indicated to the exclusion of all other methods as in the diseases of the biliary organs. The portions of the bile tract accessible to surgical treatment are the hepatic, cystic and common ducts and the gall bladder. A brief resume of the anatomy of the parts may not be amiss.

The hepatic duct is formed by the two bile ducts immediately after their emergence from the liver. It runs in the margin of the gastro-hepatic omentum in front of the portal vein and to the right of the hepatic artery for a distance of about 1½ inches, when it is joined by the cystic duct to form the common duct, or ductus communis choledochus, which continues the course of the hepatic duct in the free margin of the gastro-hepatic omentum, running posterior to the first portion of the duodenum, then to the inner side of the second portion and finally between the head of the pancreas and the duodenum; enters the coats of the intestines, running obliquely for a distance of ¾ inch, expands into the ampula of Vater, and, together with the pancreatic duct (the duct of Weirsung), opens into the intestine at the papilla biliaria at a distance of about 4 inches from the pylorus. The gall bladder is situated in the fissure vesicle on the under surface of the liver. It is about 3 inches in length and 2 inches

*Read before the Cole County Medical Society, November 8th, 1906.

broad at the fundus and its capacity is about 1½ ounces. It is pear-shaped, the fundus coming fully to the margin of the liver, and when distended rests on the transverse colon and head of the duodenum. The neck is directed backwards, upwards and to the left and is connected to the hepatic duct by the cystic duct.

The gall bladder is the storehouse for the bile during the intervals of digestion and furnishes one of the constituents of the bile, its mucous membrane being richly endowed with glands. The hepatic and cystic ducts, lying in the free margin of the gastro-hepatic omentum, can be easily palpated for stones. The blood supply is the cystic, a branch of the hepatic artery.

When we enter into a consideration of the diseases of the gall bladder, we are at once struck by the similarity of the symptoms to pathological conditions of the vermiform appendix. In both we have a simple catarrhal, a suppurative and a phlegmonous inflammation. In both we have a circumscribed or general peritonitis and a tendency to rupture with the production of a fatal result.

The diseases of the gall bladder which we will consider are as follows: Simple catarrhal cholecystitis; suppurative cholecystitis or empyema of the gall bladder; acute phlegmonous cholecystitis; infective cholangitis; suppurative cholangitis; cholelithiasis or gall stones.

Simple catarrhal cholecystitis is a well-known and mild affection characterized by slight jaundice, some pain and slight enlargment of the gall bladder though it is rarely palpable. The disease usually yields to medicinal treatment and rarely, though occasionally, requires surgical intervention. However, a large number of cases of simple catarrhal cholecystitis are referred to the surgeon with the diagnosis of gall stones, the patient having suffered violent attacks of colicky pain and vomiting, followed by slight jaundice. These attacks are due to plugs of mucous and not to stones. Some cases of simple catarrhal cholecystitis, however, come to the surgeon, having resisted all forms of medical treatment, no matter how vigorously applied, with a shrunken gall bladder, the coats of which are enormously thickened and the gall bladder filled with a thick ropy mucous which does not contain bile. The proper treatment for these cases is a cholecystotomy with prolonged drainage. The details of the operation will be described later.

Simple suppurative cholecystitis results frequently from an untreated case of catarrhal cholecystitis, or as a sequel of enteric fever. It is characterized by slight jaundice, marked enlargement of the gall bladder and a hectic fever. There is a tendency to rupture and always extensive ulceration of the mucous membrane. In this class of cases a cholecystotomy with prolonged drainage is necessary though if upon inspection the gall bladder is found hopelessly damaged, a cholecystectomy may be necessary.

In phlegmonous cholecystitis we have a truly surgical disease and

one in which medicinal treatment, other than supportive measures, can but lead the patient closer to his grave. Here we have an infection so virulent in nature that the resisting powers of the human organism are totally unable to cope with it and hour by hour the disease marches steadily through the coats of the gall bladder and perforates into the general peritoneal cavity.

With the violent pain of peritonitis, an ashen pallor, a cold clammy skin, and weak, thready pulse, the patient is soon doomed if not relieved by surgical intervention.

These cases demand different treatment according to whether perforation has occurred or not. If seen before the occurrence of perforation a cholecystectomy is demanded. If general peritonitis has occurred Murphy's treatment should be instituted which will be described under technic.

Simple catarrhal cholangitis is merely a violent catarrhal inflammation with jaundice, a slightly enlarged liver and Charcot's fever. These cases usually yield to medicinal treatment though in severe cases an anastomosis between the gall bladder and the duodenum (cholecystenterostomy) may be done.

In suppurative cholangitis we have a more violent infection, with colicky pain, an increasing, never fading jaundice, rapid pulse, enlarged liver, which is very painful, and hectic fever. These cases demand a drainage of the gall bladder and ducts.

It is however in the treatment of gall stones that we find the most contention existing between the internist and the surgeon. And though one might as well try to dissolve Pike's Peak with a bucket of water, many physicians continue to deluge their patients with various salts of lithium, olive oil and what not, in the hope of dissolving these stones.

When closely questioned these men, in imitation of the agent of some new lithium salt, put a stone in a test tube and pour over it some lithium salt and as it slowly dissolves, give a wink of satisfaction and refuse to further discuss the question.

But the body is far more complex than a test tube and maliciously refuses to give up its stones on any such manoeuver. By the administration of these various remedies he has merely subdued the inflammation, but the stones remain; a condition not to be despised, but there is a subtle sleeping danger which, while it may never again trouble the patient, may bring about a fatal result.

I quote the following from Dr. Bridge's discussion on gall stones from the standpoint of the physician:[1] "We are taking great personal danger all our lives and with the lightest thought, but if one suffering from gall stones to the extent of producing marked symptoms could minimize to the lowest point his danger of death from them he would probably have them dealt with surgically."

Again Dr. John B. Deaver, says:[2] "I am in favor of removing

gall stones in every case in which they are present provided of course there is no complication which could render a surgical operation injudicious. But when operation is done early in the disease it is so free from danger and the results so satisfactory that it seems to me to be courting disaster to postpone operation in the hope that the symptoms will disappear never to return."

A. W. Mayo Robson[3] points out that in his experience the danger of passing a gall stone is greater than operation. Further A. C. Wood[4] of Philadelphia has reported twenty-two cases of intestinal obstruction from gall stones, and I have myself seen since then a case of death from impaction of a gall stone in the ileo-cecal valve, the stone having ulcerated from the gall bladder into the duodenum. Then too a stone may become lodged in the ampula of Vater forming a ball valve stone, a condition fraught with great danger and high mortality. So we see that viewed from all sides surgical treatment is the treatment of choice and it is the duty of all physicians to urge surgical treatment.

I am aware however that many patients refuse operation. Well and good; they are his stones and if he prefers to keep them and court death that is his privilege and the physician must treat him along the Carlsbad line remembering however that by medicinal treatment he but initiates a period of latency, and that concretions passed after the administration of olive oil are but emulsified masses of that substance.

Operation. If the patient is deeply jaundiced it is well to administer 30-60 grs. calcium chloride for the 24 hours preceding the operation and 60 grs. by enema following operation. This increases the coagulability of the blood and prevents a fatal oozing which is apt to occur in these cases.

We make Bevan's incision which extends from the cartilage of the eighth rib along the side of the right rectus for a distance of about 5 inches. This is the best incision as it permits of enlargement above and below forming an S shaped incision. The gall bladder is walled off with gauze and if distended is aspirated before it is opened. The gall stones are removed with a scoop or forceps; the ducts are explored by inserting the index finger in the foramen of Winslow and palpating with the thumb. If stones are found in this situation they are worked back into the gall bladder and removed. or if they can not be forced back, the duct is incised and the stones removed, and if possible the duct is sewed; if it is not possible to sew the duct, a drainage tube is inserted to this point and packed with iodoform gauze.

The gall bladder is flushed, the pads removed, and it is sewn to the aponeurosis, never to the skin as a biliary fistula will result; a drainage tube is inserted and left in place until the discharge becomes clear.

The wound is then sewed only by Lembert sutures.

Technic. The operation described for the removal of stones is

that of cholecystotomy. Bevan's incision is made and the cystic duct explored. Gauze pads are packed about the gall bladder and the gall bladder is aspirated. The cystic duct is exposed and tied with two silk ligatures and cut between, the end touched with phenol followed by alcohol. The peritoneum is incised and the gall bladder removed. The ragged edges of the peritoneum united with silk covering the cut end of the cystic duct and reinforced by several mattress sutures. The wound is closed as follows: Silk for the peritoneum, catgut for the muscles and silkwormgut for the skin.

Personally, I do not believe in through and through sutures as used by some men at the present day, as dead space cannot be obliterated unless such force is used as to cause the stitches to cut and there is more danger of infection. In speaking of perforation, I mentioned Murphy's treatment for peritonitis. Heretofore the overwhelming majority of cases of peritonitis died. To-day we save 45 per cent. against a former 1 per cent. Formerly, and by that I mean within the last year, we opened the abdomen, eviscerated the intestines, and inch by inch scraped off the plastic lymph. The entire abdomen was gone over in a like manner and the entire cavity flushed, with the uniform result that 99 per cent. of these patients promptly and unhesitatingly died. Dr. Murphy pointed out that we did too much. In scraping off the lymph we opened millions of lymph channels to absorption that nature had sealed and, by flushing the cavity, diffused the toxic material over the entire abdomen. So we have made a change in our treatment of peritonitis. By this method a reversal of the lymph current takes place and instead of the toxic material being spread over the entire abdomen by flushing, which was poor cleansing at the best, the drainage is thorough and concentrated toward the wounds. It is carried out as follows: Four incisions are made, one in each loin and one in each groin. The intestines are not disturbed nor is irrigation practiced. Drainage tubes are inserted in each incision. The patient is placed in the semi-erect posture and a rubber catheter, connected to a container filled with hot water, is inserted in the rectum so that it will flow drop by drop, the patient so remaining day by day until all symptoms are improved. In a recent case in the Jefferson Hospital, Philadelphia, a case of peritonitis from appendicitis in which the entire cavity was filled with pus, the patient, under this treatment, absorbed 11 gallons of fluid and 9 gallons poured from the wounds in 24 hours. The patient recovered. Murphy reports 73 cases with 45 per cent. cures. So this method recommends itself to the exclusion of all others for peritonitis and while many methods are still being used, the pendulum of condemnation of modern surgical thought is fast relegating them to oblivion and obscurity.

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A NEW AND SIMPLE METHOD OF TREATMENT FOR WARTS, WARTLIKE MOLES, ETC.

BY HUGO W. BARTSCHER, M. D., ST. LOUIS.

Physicians are frequently consulted by patients who have passed middle life, in regard to moles and warts on the forehead, temple or elsewhere on the face or head. The attention of these patients has, in most instances, been drawn to their moles by signs of activity in them, manifested either by an increase in size or otherwise, and fearing malignant disease, they seek their doctor's advice.

If you suggest removal with the knife your patient will want to think it over, the result being that he will not return. Electrolysis, if feasible, or caustics, if safe, likewise do not meet with approval.

In these cases I use a dressing of a one or two per cent. solution of purest carbolic acid. The application is made in the following manner (by the patient himself) :—A pledget of cotton or a piece of lint of sufficient size to just cover the mole, is well saturated with a one or two per cent. solution of carbolic acid and applied to the surface of the mole; this cotton is then covered with a piece of gutta-percha tissue of such size that its edge extends sufficiently beyond the margin of the cotton everywhere to prevent evaporation; the whole is then held in position with a bandage or strips of adhesive plaster. If convenient to the patient the application may be renewed morning and evening; if not convenient, I direct the patient to apply the dressing at night and to apply a little vaseline at intervals during the day. This treatment, faithfully applied as it usually will be, will remove the mole or wart without leaving a scar.

Having used this method, which I discovered by accident, for many years and in a sufficient number of cases, and invariably with success, I feel justified in recommending it to the profession.

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EDITORIAL.

THE STATE BACTERIOLOGIST.

One of the many functions of the Boards of Health of the various states is to provide laboratory facilities to the general practitioners living throughout the state equal to those at the command of the city physicians. For many years the larger cities have placed at the disposal of the physician laboratories that can undertake certain examinations.

In comparatively recent years the lack of such opportunities has been felt by those living away from the cities and the Boards of Health have undertaken to supply the deficiencies. To that end there is in most states a State Bacteriologist, whose duty is mainly to examine specimens of sputum for tubercle bacilli, cultures from throats for the organism of diphtheria and to make the Widal reaction in cases of suspected typhoid fever.

The appointment of a State Bacteriologist is, however, not all that is necessary. He, alone, cannot accomplish much; it is only when in active co-operation with the practitioner that results beneficial to all are obtained. The individuals benefited are the patient, the doctor, and the State. The patient gains the point of an accurate diagnosis of his condition, the physician becomes accustomed to calling to his aid methods that he himself may not have the time or possibly the skill to employ; the State is the gainer in that the less sickness there is the less are the demands made upon it for financial support.

In many instances the patient is unable to pay a private individual for the necessary work, the physician cannot afford it and if he is unable to do it himself the examination is not made and everyone may suffer as a result.

It is at this point that the State must, for its own self-protection come to the front and provide what means it can for the safe-guarding of its citizens. After the means have been supplied it then becomes

not only the privilege but the duty of the physician to avail himself of them. He no longer has any excuse for exposing the community to infection as the result of a mistaken diagnosis, when with a little trouble and practically no expense he can have the necessary laboratory examinations made.

At present when tuberculosis, diphtheria and typhoid fever are so important in their bearing upon the health of a community it is the duty of every physician to do his best to subdue, if not eradicate, the ravages of these diseases. It is the physician who in every city, town and village must watch over the health of his neighbors. All advances in hygiene and sanitation must come through the doctor to the laity. They in turn should become educated to the point of demanding that all methods available for the prompt and accurate diagnosis of disease be employed.

LOCAL SOCIETIES FOR THE RELIEF AND PREVENTION OF TUBERCULOSIS.

Interest in the formation of local Societies for the Relief and Prevention of Tuberculosis is growing and we are glad to remark a considerable activity in this direction among the affiliated county societies. St. Louis has had a society for some time, which is doing most excellent work in extending a knowledge of ways and means to prevent the spread of the disease among that class most afflicted and least capable of protecting itself from infection, both on account of ignorance and lack of necessary means. Ralls County has a good working society and Howard County will soon complete the organization of its society.

Jackson County is in line with a society, organized on September 26th. The initial meeting was attended by many of the prominent citizens of Kansas City, including business men, physicians, ministers and charity workers. The Society purposes to raise sufficient funds to lease land near the city, on which to place a tent colony and later erect a sanatorium for the treatment of incipient cases. Kansas City has purchased land in Clay County to be used for a tuberculosis camp, and Jackson County Medical Society, therefore, will have the co-operation of Kansas City in this work. The officers of the Jackson County Society for the Relief of Tuberculosis are: Dr. R. O. Cross, president; John T. Smith, first vice-president; The Rev. Wallace M. Short, second vice-president; J. W. Frost, third vice-president; E. A. Krauthoff, fourth vice-president; Dr. C. B. Irwin, secretary; Albert Marty, treasurer. Dr. E. L. Stewart is chairman of the Committee on Publicity.

There is no more important move in which our affiliated county societies could engage at this time than that of forming local Societies for the Relief and Prevention of Tuberculosis. In September, 1908, the International Congress on Tuberculosis will convene at Wash-

ington, D. C., and Missouri should be able to report creditable progress in its work. The State Committee of the International Congress for Missouri consists of the following: Dr. H. Wheeler Bond, St. Louis; Dr. W. J. Calvert, Columbia; Dr. Geo. Homan, St. Louis; Dr. Frank J. Lutz, St. Louis; Dr. William Porter, St. Louis; Dr. W. S. Thompson, Armstrong; Dr. Louis M. Warfield, St. Louis.

MAJOR JAMES CARROLL, U. S. A.

The death, in Washington, D. C., September 16th, of Major James Carroll, Medical Department, United States Army, marks the passing of a man to whom the whole civilized world, and especially the medical profession, owes a debt of gratitude; and illustrates, in a striking way, what may be accomplished in our country entirely by one's own efforts.

Major Carroll was a self made man but so thorough was he in all his work that he had placed himself, while yet a comparatively young man, among the few whose privilege it has been to permanently benefit mankind.

Born in England in 1854, he came to this country a poor boy and, at the age of twenty had become so thorough an American that he enlisted in the army and all his subsequent life was spent in faithful service to his adopted country. Beginning as a Private in the 1st Infantry he served through the successive grades of Corporal, Sergeant, and 1st Sergeant and then, at his own request, was appointed to the position of Hospital Steward which gave him a better opportunity to follow the scientific inclinations he possessed.

While stationed in Washington and Baltimore he found time to study medicine and was graduated from the University of Maryland in 1891, later doing post graduate work at Johns Hopkins. Even after receiving his degree he continued in the Army service, being stationed at the Army Medical Museum where he devoted himself to research work.

At the beginning of the Spanish-American war he was appointed Acting Assistant Surgeon and it was in this capacity that his great work in Cuba was done. Just a few months before his death, after vigorous efforts on the part of the organized profession of the country, he was, by special act of Congress, promoted to the grade of Major in recognition of that work.

The investigation, undertaken by the Government, into the etiology and transmission of yellow fever furnished the opportunity for him to show those qualities of courage, self sacrifice, and scientific knowledge, which were his. With the fruits of the work he did there every medical man is familiar; but one who has not lived in the yellow fever zone, and is unfamiliar with the devastation wrought by that disease, can scarcely appreciate the enormous saving in lives and

money resulting from the experiments instituted by Major Carroll and to which he first submitted himself.

Mainly because of his labors yellow fever, which had annually claimed its thousands and made necessary the maintainance of a costly quarantine at all our southern ports, is thoroughly understood; and an application of sanitary measures on the basis of the truths discovered by him is rapidly making it a rare disease. And our admiration for the sublime courage which permitted him to offer himself in proof of his theories and calmly submit to the bite of a mosquito, which had previously bitten three persons suffering with the disease, should be coupled with our gratitude for what he has done for humanity.

The heart trouble which finally caused his death could be traced directly to the illness which followed his voluntary infection and he literally gave his life that others might live. A plain, modest, unassuming, man, his entire life is a shining example of thorough, painstaking work and conscientious devotion to duty. And in laying down his earthly burdens it must have been some satisfaction for him to feel that he had alone and unaided, not only brought himself to the foremost rank in his profession but that the benefits of his work would be felt by every succeeding generation.

THE ST. LOUIS MEDICAL SOCIETY.

The St. Louis Medical Society has revised its constitution and by-laws and made some very important changes in its provisions. The new constitution provides for the division of the Society into sections and limits the meetings of the general body to twice a month. Each of the various sections will meet probably once a month, though no limitation is placed upon the number of meetings. The sections will elect their officers and provide rules governing their deliberations, but only members in the sections can hold office or vote in the sections. Only members of the St. Louis Medical Society are eligible to membership in the sections but all members of the Society may attend the meetings of the sections.

A Council, consisting of twelve members, has been formed with duties somewhat similar to those of the Judicial Council of the State Medical Association. This Council will be the legislative and business body of the Society and is empowered to elect certain officers. The Council also will elect all members of the Society.

The Nominating Committee, consisting of five members, will prepare a ballot, for the annual election of officers, containing the name of one member for each office to be filled. These ballots will be mailed to the members, who will cast their votes by returning them through the mail to the secretary of the Society after having indicated their choice of candidates. Additional names for offices to be

filled may be added to the ballot provided by the Nominating Committee upon the application of twenty members. Each voter also is permitted to change the ballot and substitute the name of any member for the one printed on the ballot. By this method all members of the Society can vote for the election of officers without the necessity of attending the annual meeting.

The Secretary and the Treasurer are to be salaried officers. Hitherto the Secretary has served without compensation, while the Treasurer has been allowed a percentage of the amount of dues collected. The Chairmen of the various sections are to be the Vice-Presidents of the Society.

The Weekly Bulletin of the Society is to be enlarged and will be, in fact, a medical journal, in which will be published the papers or abstracts of papers that are read before the Society and the various sections, the programs of the meetings of the sections and the general sessions and all matters of interest to the members of the St. Louis Medical Society.

The following sections have been organized up to the present time: Surgical, Internal Medicine, Ophthalmological. The Oto-Laryngological Section will soon complete its orginization.

The Society has under consideration the establishment of a medical defense fund for the protection of its members in civil suits for malpractice. A large majority of the members have expressed themselves in favor of the plan.

MEDICAL ASSOCIATION OF THE SOUTHWEST.

The Medical Association of the Southwest will hold its second annual meeting in Hot Springs, Ark., on October 8, 9, 10. The outlook points to a very successful and profitable meeting. All members attending the meeting should secure a certificate from the agent selling the tickets so that the benefit of a reduced rate may be had.

The meeting will be divided into three sections, medical, surgical and ophthalmological. The program for each section is well filled and indicates the very great interest manifested by the members in this association. Dr. Jabez N. Jackson, of Kansas City, is Chairman of the Surgical section.

The committee of arrangements at Hot Springs announce that special arrangements are being made for the entertainment of the members and their families. Those who have tasted of the pleasures provided by the physicians of Hot Springs in the past know that nothing will be omitted which might contribute to the comfort and pleasure of the members attending this meeting. Dr. Thos. E. Holland is chairman of the committee of arrangements.

COUNCILOR FOR THIRD DISTRICT.

The executive committee of the Judicial Council has appointed Dr. E. W. Whitely, of Albany, councilor for the third district, vice Dr. W. E. McKinley who has resigned to accept the appointment as assistant physician in State Hospital No. 2, at St. Joseph.

A CORRECTION.

In the article by Dr. Outten, printed in our September issue, there occurred an error which we regret very much and which we now wish to correct. On Page 141 Dr. Outten was made to say that Dr. J. D. Griffith, of Kansas City, "performed, in St. Louis, in 1877, the first operation of resection of a rib for the treatment of an empyema—an operation now one of the recognized procedures. In 1883 at the meeting of this Association, which was held in Mexico, Missouri, he reported the first case of gastrostomy as a palliative measure in cases of malignant stenosis of the œsophagus, and in 1889 he popularized the operation of wiring of the patella for fracture produced by indirect violence, and reported a series of cases and the results obtained to the National Association of Railway Surgeons." Dr. F. J. Lutz, of St. Louis, is the one to whom credit is due for these operations.

The Jackson County Medical Society will soon publish its proceedings in journal form. The weekly bulletin will be discontinued in its present form and reissued under the title of the "Jackson County Medical Review." The programs of the meetings will be published in the Review, as well as papers read before the Society and all other matters of interest to the profession of Jackson County. The first number will appear early in October under the direction of Dr. E. L. Stewart, secretary of the Jackson County Medical Society.

The Washington State Medical Society has instructed its judicial committee to take some action to promote more intimate relations between state and county legal and medical societies, as it is desired to bring these two professions closer together for the common good.

The officers for 1907-1908 are: President, Dr. C. N. Suttner, Walla Walla; first vice-president, Dr. W. H. Axtell, Bellingham; secretary, Dr. C. H. Thompson, Seattle; treasurer, Dr. L. L. Love, Tacoma; delegate to the American Medical Association, Dr. J. R. Yocum, Tacoma.

The constitutionality of the Washington state medical practice act has been upheld by the United States Supreme Court in the case of the State of Washington against O. W. Lawson, charged with practicing medicine without a license. As a result of the action of the United States Supreme Court Lawson will have to go to the county

jail and serve the remainder of a ninety day sentence. Lawson was arrested at the instance of the King County Medical Society, the case being the first of its kind to go before the highest tribunal in the state.

The Wisconsin State Medical Association has appointed a committee to prepare a plan for establishing a defense fund for the purpose of protecting its members in suits for malpractice. The committee is to report at the next annual meeting of the association. The report of the committee will be submitted to the Judicial Council of the Association in January, 1908. The probable plan that will be submitted is to create the fund by a per capita tax of $1.00 upon each member in addition to the annual dues for membership in the Association, which is now $2.00, thus making the annual dues $3.00. The proposition is to be submitted to each county society after having been passed upon by the Judicial Council.

The Iowa State Medical Society adopted resolutions at its last annual meeting creating a medical defense committee. A medical defense fund is to be raised by assessing each member $1.00 per annum, in addition to the regular membership dues, and this fund is to be set aside for use in protecting the members against suits for malpractice. $300.00 was appropriated from the general fund to be drawn upon until the regular fund may be available.

The Minnesota State Medical Association at its annual meeting in August adopted resolutions which will doubtless result in better organization and more effective work. One committee was appointed to draft a new medical practice act, under competent legal direction, which will be introduced at the next meeting of the legislature. Another committee was instructed to prepare rules for establishing a medical defense fund to be used in the defense of members against whom suits for malpractice may be brought. Contract practice for lodges and fraternal insurance bodies was condemned. The association has a membership of 1159. The officers for 1907-1908 are: Mr. W. H. Magie, of Duluth, President; A. B. Stewart, Owatonna, first vice-president; Thos. McDavitt, St. Paul, secretary; R. I. Hill, Minneapolis, treasurer.

A woman physician has been appointed health officer of the city of Portland, Oregon. She is Dr. Esther C. Pohl, a graduate of the medical department of the University of Oregon. For two years she has been a member of the city health board. She is said to be well qualified to fill the duties of the office, which carries a salary of $3,000.

The American Association of Railway Surgeons meets in Chicago on October 16, 17 and 18.

CORRESPONDENCE.

To the Editor of the Journal.

Dear sir: For several years the question has been discussed whether the meeting of the State Association should be held in the fall instead of in the spring. Th principal reason for urging the change has been the short interval which occurs betwen the meeting of the State Association and that of the American Medical Association. It is urged that attendance upon the latter is impractical for many who have attended the State Association. This year the officers of the American Medical Association have advised that we change the time of meeting of our State Association. The Executive Committee of the Judicial Council, through its chairman, conferred with the President of the Association who concurred in the opinion that a change in the time of meeting should not be made without the expressed assent of the county societies represented in the House of Delegates, even though it were practical to hold a successful meeting of the State Association this fall; and the official reply to the request of the American Medical Association was in conformity with this view.

It is, however, suggested that since this matter is being agitated, the county societies consider it during the coming winter and instruct their delegates so that they may voice the sentiments of the county societies when the question comes up for discussion at the May meeting of the Association in Springfield next year.

Yours truly,

F. J. Lutz,
Chairman Judicial Council.

St. Louis, September 26th.

OBITUARY

D. R. Corbin, M. D.

David Riley Corbin was born in 1875 in Stoddard County, Missouri. He was educated in the common schools and at the State Normal School, at Cape Girardeau. He received his medical degree from the medical department of Vanderbilt University in 1899, and was licensed to practice medicine in this state in the same year. He located at Bernie, Missouri, remaining there for about two years when he removed to Bloomfield, and remained in the practice of his profession at that place until his death on August 10, 1907.

Dr. Corbin was a capable physician, enjoying the confidence of his patrons and the esteem of his professional brethren. He was deeply interested in the success of professional organization. He was the prime mover in the formation of our county society and was made its first secretary and the next year he was elected president. He filled both these offices with ability and satisfaction. He was regular in his attendance at the meetings of the Society, being absent only when prevented by sickness in his family. He was always ready to take part in any movement, or to do anything for the good of the profession. He was the delegate from our Society to the last meeting of the State Association and on the division of the district was made councilor for this district. His untimely demise is a great loss to the profession both of the county and of the state.

R. P. Cozzens, M. D.

Dr. R. P. Cozzens died at his home in Fredericktown, Mo., on July 31, 1907. He was 47 years of age. He graduated from the Barnes Medical College in 1902. He was a member of the Madison County Medical Society and of the State Medical Association.

COUNTY SOCIETY NOTES

ADAIR COUNTY MEDICAL SOCIETY.

The Adair County Medical Society held its regular meeting in Kirksville, September 7th.

Dr. Chas. Wilson, of Green City, read a paper on "A Study of the Infection of Tuberculosis in One House in a Rural District." By microscopical examination he proved three cases to have developed from the original source. The paper advocated minute doses of tuberculin in the early stage.

Osteopathic influence is strong in our county and our attendance has never been large.—J. Schooling Gashwiler, M. D., Reporter.

CAPE GIRARDEAU COUNTY MEDICAL SOCIETY.

Cape Girardeau County Medical Society held its regular monthly meeting at Jackson, September 6th. Eight members were present and Dr. Horn a visitor.

A committee was appointed to draw up resolutions pertaining to the old line life Insurance Companies asking them to come to old rate of $5.00.

Dr. H. S. Winters was given a transfer to the Scott County Medical Society. He goes to Oran.

The scientific program for the evening consisted of a symposium on "Rheumatism." The following papers were read:

Etiology, Dr. B. W. Hays; Pathology and Symptomatology, Dr. W. K. Statler; Treatment of Acute Form, Dr. Vinyard; Treat of Chronic Form, Dr. Henderson.

After listening to these interesting and instructive papers the Society adjourned to meet at Cape Girardeau on October 4th.—E. H. G. Wilson, M. D., Secretary.

CASS COUNTY MEDICAL SOCIETY.

The Cass County Medical Society held its fifth regular meeting for the present year in Harrisonville, Monday, September 12th.

All members on the program responded excepting one.

Dr. R. P. Yeagle read a paper on "Liberal Diet in Typhoid," in which he championed the growing sentiment for judicious, careful, sustaining nourishment.

Dr. R. H. Burney's paper on "Tuberculosis" showed that the Doctor has a painstaking aptitude for statistics which after all is perhaps the best method to use in getting this great subject before the laity and our lawmakers.

Dr. G. W. Farrow read his second paper on "Electric Therapeutics." This, as well as the previous paper, was a masterly presentation of the subject. The introduction of drugs into the system by galvanism was the main feature and started a spirited discussion on the whole subject of electric therapeutics and its utility.

As an exhibition of that charity which should govern the action of men, the Society authorized the secretary to express the Society's encouraging sympathy to a seriously ill fellow practitioner, though not a member of our organization.

Members taking part in discussions: G. M. Anderson, H. A. Brierly, R. H. Burney, W. F. Chaffin, H. S. Crawford, A. R. Elder, F. B. Ellis, G. W. Farrow, H. Jerard, M. P. Overholser, W. C. Palmer, H. S. Prentiss, J. S. Triplett and R. P. Yeagle; H. A. Brierly, President, M. P. Overholser, Councilor.

The Society adjourned to meet November 7, 1907.—W. F. Chaffin, M. D., Secretary.

COOPER COUNTY MEDICAL SOCIETY.

The Cooper County Medical Society met in Boonville, on Tuesday, September 3rd.

Members present:—Drs. P. L. Hurt, F. R. Smiley, R. L. Evans, J. S. Parrish, and W. H. Reynolds.

A letter from the Assistant Secretary of the American Medical Association in regard to "Contract Practice" was read before the Society. This letter was then discussed by the members present and upon a vote the usual order of business was suspended and the following motion, made by Dr. P. L. Hurt, was presented:

Resolved, That any member of the Cooper County Medical Society who persists in the practice for any social or fraternal organization after thirty days from date, shall be disqualified for membership in the Cooper County Medical Society. This motion was seconded by Dr. W. H. Reynolds after which the resolution was adopted by the unanimous vote.

Clinical cases were presented by Drs. Hurt, Reynolds, Smiley and Evans and discussions followed.

The society adjourned to meet October 1st, 1907.—Jno. R. Lionberger, M. D., Secretary.

GREENE COUNTY MEDICAL SOCIETY.

After a two months vacation the Greene County Medical Society met in regular session at Springfield, September 13th.

The Library Committee reported having bought $45.00 worth of new books. The Committee on "Open Session Meeting" reported that arrangements were being made for an early meeting. The Committee on Public Health and Legislation reported that our prosecut-

ing attorney had attended to the cases of illegal practitioners that had been referred to him. The coming meeting of the State Association here next spring was discussed. On request the name of Dr. H. Janss was dropped from our list of members. The registration of births and deaths by physicians was discussed and the majority were in favor of this registration.

Dr. Pipkin read an interesting paper entitled "The Care of the Infant." He said in part: The development of the child is influenced by inheritance, surroundings and food. The physician can partly control the surroundings and almost entirely the food. The care of the umbilicus is very important. It should be ligated and cut off about two centimeters long. The strictest cleanliness must be enforced and the dead tissue disposed of as soon as possible. After the first bath, bathing should be interrupted until the cord has fallen off; moisture favors the growth of germs at the navel; the cord should be dressed with dry gauze or cotton. The care of the eyes is important and a 2 per cent. solution of nitrate of silver or boracic acid solution may be used. A healthy child sleeps almost continuously for the first two or three days and later it sleeps 20 to 22 hours out of the 24, waking only for hunger, discomfort or pain. Training in proper habits of sleep should begin at birth.

This paper was discussed by Drs. Fulton, Ralston, Woody, Barnes, Camp, and Coffelt.

Dr. Ralston reported an interesting case of abscess of the lung with a peculiar discharge.—J. L. Ormsbee, M. D., Sec'y.

HOWARD COUNTY MEDICAL SOCIETY.

Howard County Medical Society met at Armstrong on September 6th. Present: Drs. N. E. Smith, Lee, Wright, Fleet, Bonham, Preston, White, Thompson, Hume, Richards and Watts. Visitors: Drs. J. S. Preston, and M. S. White, of Roanoke, Mo.

The scientific work of the meeting consisted in the presentation of a number of clinical cases.

Dr. Fleet presented a case of eclampsia with convulsions, in which he used the HMC tablet with fine effect, the convulsions being relieved with no bad after effects from tablet. He regards the HMC tablet as useful in all cases of severe pain.

Dr. Bonham reported a case of tuberculous ulcer of the tibia and fibula, of twelve years standing. Amputation would not be justifiable at present, and operation was advised after treatment with nutritives and creosote. Dr. White advised creosote increased to thirty or forty drops if necessary.

Dr. White presented a case of petit mal in an old man who had used the bromides for years with but little relief. With a change of the treatment to nutritives and strychnine with bromides the paroxysms were reduced to one in three weeks.

Dr. Wright presented a very interesting case of chorea with severe delirium in a girl aged fourteen years. Under soporifics and tonics she is improving.

Dr. White of Macon County Society was given a transfer card to Howard County Medical Society as he has now located at Roanoke.

As only a few of the members appointed to organize a Society for the Prevention of Tuberculosis were present, the committee was given until the October meeting to report its organization and election of officers. The committee consists of the following members: Drs. Newton E. Smith, Fayette; C. W. Watts, Fayette; Paul C. Smith, Fayette; C. F. Drake, Boonsboro; J. R. Champion, Hillsdale; W. R. Hawkins, Glasgow; J. T. Wood, Harrisburg; J. B. Fleet, New Franklin; J. Y. Hume, Armstrong and M. S. White, Roanoke.

The Society extended a vote of thanks to Drs. Hume and Thompson for the splendid entertainment provided for us at the Morris house and to the citizens of Armstrong for their liberal provisions.—C. W. Watts, M. D., Reporter.

THE JASPER COUNTY MEDICAL SOCIETY.

The Jasper County Medical Society met in regular session at Joplin, September 17th. The following members were present: Drs. Shelton, Matthews, Bonnett, Lanyon, Grantham, Webb, Donohoo, Anderson, Miller, S. H., Willim and James; visitors: Drs. Baker and McAlester of Joplin.

Dr. Donohoo reported an interesting case of myeloginous leukemia. By request the doctor will make a full report of the case at the next meeting.

Dr. Grantham reported the case of a young man who came to him with diagnosis of appendicitis. On operating he found the trouble to be of gall bladder origin and adhesions due to a previous attack of peritonitis. Dr. Grantham removed a stone that completely filled the gall bladder.

Dr. Neff stated that men of national reputation sometimes mistook gall bladder disease for appendix disease, only finding out the mistake after making an incision.

Dr. Lanyon reported the case of a man who had marked symptoms of appendicitis, suffering severe pain, vomiting, etc. After consultation operation was decided upon but the patient refused to submit to operation. Gave anodyne treatment to relieve pain and in a few days all symptoms had disappeared.

Dr. Granthanm exhibited a recent specimen of section of the lower end of the ascending colon and cecum without the slightest indication of there being any verniform appendage. The specimen was a rare and valuable one.

The taking up of post graduate work was freely discussed and

the following committee was appointed to formulate plans and suggest an outline best suited to the Society: Drs. Lanyon, Bonnett and S. H. Miller.

Action on the charges of unprofessional conduct brought against Dr. Z. T. Blackwell was postponed till the next regular meeting.—R. M. James, M. D., Secretary.

JACKSON COUNTY MEDICAL SOCIETY.

The first regular meeting of the Jackson County Medical Society, following summer vacation, was held at Employer's Association Hall, Tuesday evening, September 17th, there being present in all thirty-four.

Dr. C. C. Conover presented a case for examination which he had diagnosed as aneurysm, probably of the aorta. The patient gave a history of syphilis contracted years ago, and presented a pulsating enlargement over the precordial space. He complained of pain in the second interspace, which grew much worse about three months ago; voice bore a brazen metallic tone; paralysis of right laryngeal muscles. The chair appointed as a committee to examine the patient and report, Drs. Hyde, Thompson, Swaney, McArthur and F. M. Lowe, all of whom, after examination, confirmed the doctor's diagnosis. X-ray picture showed shadow over the aneurysm.

Next on the program was a paper by Dr. W. A. Shelton, entitled "Some Injuries of Joints," giving first a description of the different dislocations of elbow and shoulder, illustrated by the use of x-ray plates in a most beautiful manner. He also presented these different patients from whom the pictures were made. (For full text of this paper see page 212). Dr. A. W. McArthur opened the discussion. and reported a case of fracture of the anatomical neck of the humerus, upon which he and Dr. Reynolds had operated less than one week ago. The head of the bone was located posterior to the axilla. The operation consisted of dividing the pectoral muscles after the Jackson method of breast amputation, separating the softer tissues gently and retracting the head. Others discussing the paper were Drs. Pearse, Hill, McCrea and Luscher. Dr. Shelton closed the discussion. The x-ray plates, which were remarkably plain, were prepared and demonstrated by Dr. O. H. McCandless.

In executive session the hall committee was authorized to spend the sum of $500.00 per year for renting a new hall, the regular meeting place of the society having been burned in the Pepper Building fire.

To members of the State Society an invitation is extended to meet with us at any time you are in the city. Our regular meetings are held every Tuesday evening, the last meeting of the month being devoted to clinics, demonstrations of pathological specimens and instruments. We always have a place on our program for visiting members.—E. L. Stewart, M. D., Secretary.

LAWRENCE-STONE COUNTY MEDICAL SOCIETY.

The Lawrence-Stone County Medical Society met at Aurora, September 3d. The following members were present: J. A. Harris, J. P. Andrews, C. A. Moore, A. H. Madry, F. S. Stevenson, J. B. Fleming, I. A. Cottingham, W. W. Rodman, J. A. Melton, J. H. Craven, J. P. Baird, W. M. Holmes, W. S. Loveland, T. D. Miller, R. W. Smart, E. E. Wade, N. F. Terry, with Drs. G. B. Darrel of Republic, Ben. H. Smith, of Springfield, and Monday, of Aurora, visitors.

Dr. Harris moved that a reporter for the Society be elected and Dr. Madry was afterward elected for the position.

The scientific part of the program was opened by Dr. T. D. Miller, who reported a case, "Post Operation on Fractured Tibia." A child four years old had fallen from a high chair when two years old and had fractured the tibia of the left leg and bent the fibula, producing great deformity; had been treated by the former surgeon as a dislocation. Skiagraphs taken before and after operation were presented to the Society. The first showed the fractured end of the tibia united nearly at right angles to axis of the upper portion. The operation consisted of opening down to the bone over the angle made by the two fragments and refracturing the tibia, after which the parts were brought into line and fastened in position with plaster paris dressing. The result was a straight leg, union good and one inch shortening. The second skiagraph showed bone projecting at what was the outer angle before the operation. This would necessitate a second operation for its removal.

Dr. Wade thought Dr. Miller should be complimented for the successful outcome of the operation and the good result obtained.

Dr. Smart said that undesirable cases were often forced upon the physician but fortunately there was nearly always a way out if the physician would apply himself to the task imposed. He had had little experience with fractures of the tibia but broken femurs had given him annoyance.

Dr. Madry said the skiagraph showed an oblique fracture of the tibia, and the fibula bent into a rainbow shape. He would have probably used a chisel, or if a saw he would have followed the line of fracture.

Dr. Harris said the practicing physician felt the needed benefit the x ray gives in diagnosing injuries and indicating the proper adjustment of the injured parts. He thought the operation performed by Dr. Miller a success.

Dr. Miller stated in closing that he had expected the gap made by the saw and fracture to be filled in with exudate.

Dr. G. B. Darrel presented the next subject, "Hyoscine Anesthesia," making report of ten cases in which he had used the W. A. combination. Dr. Darrell said at the outset that this remedy, like all other powerful ones, could be and had been abused. In cases of labor,

if not used right and at the proper time, we were liable to have bad results. The following cases were reported:

Case I. A labor case that received a dose when the cervix had been partially dilated. The anesthetic acted well leaving no unpleasant results to mother or child.

Case 2. Submucous fibroid of the uterus; received two doses that produced complete anesthesia while cervix was being dilated and the tumor being removed. No bad after effects.

Case 3. Twins; labor well along when the doctor arrived. Gave one dose when the cervix was sufficiently dilated and one hour later gave another dose. The only bad after effect noticed was that one of the twins remained quite sleepy some hours.

Case 4. A labor case; received two injections that acted well, stopping some abnormal contractions.

Case 5. Labor case; received an early injection that seemed to stop all pains or contractions, and the doctor went home to be called again. Case ended well.

Case 6. Labor case; mother did well but baby was very sleepy and required half hour to resuscitate.

Case 7. Labor. Another doctor had spent a day and night with the patient and had given the anesthetic, which seemed to prolong the labor. Forceps were applied and delivery effected without any untoward effects on mother or child.

Case 8. Labor, 48 hours duration; membranes rupturing; twenty-four hours after commencement both child and mother died.

Case 9. Retroverted uterus and painful menstruation; gave two doses one hour apart and then a little chloroform; replacement easily and painlessly effected.

Case 10. Labor easy and almost painless and no bad effects to mother and child.

Dr. Darrell advised withholding the anesthetic until the second stage in labor cases, when the cervix is being fairly well dilated, that the child may not be too long exposed to the action of the anesthetic.

Dr. Rodman thought there was an effect in the combination not obtained in the substances given singly. He believed one of the cases was not ready and should have had a dose of morphine. He objected to so prolonged an effect as hyosciamine produced and preferred chloroform.

Dr. Andrews considered the anesthetic too new, as used in the combination, to allow the profession time for the formation of definite opinions as to its value. He had given the hydrobromate of hyoscymus in a case of puerperal sepsis but the patient had gotten spts. frumenti also. He thought such powerful therapeutic agents dangerous and preferred choloroform in labor, that being safer for the child.

Dr. Smart called attention to profuse post-partum hemorrhage

as probably assignable to the use of hyoscyamine in labor cases. He had found difficulty in obtaining contractions. He did not fear the anesthetic effect but believed chloroform should always be given.

Dr. Wade had used the agent in a case of breach presentation and succeeded in turning, but child died shortly after delivery.

Dr. Fleming had not used this anesthetic and said he seldom used an anesthetic in labor cases. He had recently been called to see a three weeks' old baby whose mother had received the anesthetic at delivery. He found the inferior maxilla dislocated and the skull fractured. The child died a day or two later of traumatic meningitis. He considered Dr. Smart's cases of hemorrhage due to the fact the anesthetic stopped all after pains.

Dr. Terry thought hyoscyamine not identical with scopolamine but the difference largely one of purity; the latter he considered a dangerous drug. He considered the remedy under discussion one of value but thought commercial interests had to be taken into account when considering hyoscyamine anesthesia reports. He had observed in surgical cases that when given previous to chloroform it allayed the patient's fears of chloroform and shortened the time, eased the effort of anesthetizing and obviated the tendency to vomiting after operation. Nobody had used this agent 3,000 times, yet all had something to say of danger. He was afraid of it for complete anesthesia and believed we did not yet understand all the dangers that might come from its use.

Dr. Smith said his experience had been limited to surgical and nervous disorders; that the use of hyoscyamine had been abandoned in treating morphine and cocaine habits. He regarded any therapeutic agent dangerous that reduced respiration to 3 or 4 per minute.

Dr. Miller believed the analgesic effects were better than ¾ grain morphia produced.

Dr. Andrews advised caution in cases where albuminuria existed but thought it might fit in the niche where chloroform and ether were contraindicated, as in lagrippe.

Dr. Harris considered the combination as being in the experimental stage and did not believe the virtues new-found. He recommended a middle ground.

Dr. Darrell in closing warned against giving the agent too soon. Had not in surgical cases noticed slow expiration.

Dr. Smart reported a case of premature labor due to diseased placenta. There were hemorrhages and strong contractions but dilation of cervix did not proceed. After repeated attempts to dilate with finger and dilator, patient was anesthetized and a partial dilatation was made through which the dead fetus was taken out in pieces. Patient was reported dead at close of operation but soon revived and made uneventful recovery.

The report was discussed by Drs. Craven, Andrews, Stevenson, Darrell, Madry, Ferry and Rodman.

Drs. Darrell and Smith were made honorary members.

On motion the society adjourned to meet at Crane, Stone County, December 3d, at which time the election of officers for the year 1908 will take place.—A. H. MADRY, M. D., Reporter.

MORGAN COUNTY MEDICAL SOCIETY.

The Morgan County Medical Society met in regular monthly session at the residence of Dr. P. G. Woods, Versailles, on August 14th. Present, Dr. Chas. Fry, of Syracuse, Mo., Drs. Gunn, Lutman, Short, Well and Woods of Versailles.

The committee on arrangements for an open session of the Society reported that the date had been set for Wednesday, September 11th. The meeting will be held in the Circuit Court Room, Court House, Versailles.

The following resolution was adopted by the Society:

"Whereas it is incompatible with honorable standing in the profession, and in direct violation of the National Code of Ethics, which has been adopted as the Code of this Society, to publish cases or operations in the daily prints, or to suffer such publications to be made in connection with our names as physicians and surgeons, be it

Resolved, by the members of the Morgan County Medical Society that we denounce the too common practice of having our names associated with the reports of cases or news items pertaining to professional services and that we will use our best efforts to prevent the same."

The remarks by Dr. Chas. Fry, of Syracuse, on organization were endorsed by all the members.

The next meeting will be held at Versailles, Wednesday, September 11th.—H. N. LUTMAN, M. D., Secretary.

SHELBY COUNTY MEDICAL SOCIETY.

The Shelby County Medical Society met in regular session at Shelbina on September 24th.

Dr. Carson reported an epidemic of sore throat in his locality which he believed to be follicular tonsillitis. Several cases of diphtheria were reported in different parts of the county. A good discussion by Pollard, Vaughan, and Chapman on follicular tonsillitis and diphtheria followed. All agreed that the safest plan was to administer antitoxin in all questionable cases.

Dr. Carson read an excellent paper on "Follicular Tonsillitis followed by Locomotor Ataxia." He used a preparation of animal lymph with remarkable results. He had used it in a case of long standing, obscure stomach trouble, but which he believed to be neurotic, with good results.

Dr. Wood believed the lymph treatment had no scientific foundation and if it did good it was because it contained well known drugs.

Dr. Smith had used it in a patient with lateral sclerosis with no benefit.

This was an unusually interesting and profitable meeting which all enjoyed.

Adjourned to meet in December.—A. M. Wood, M. D., Reporter.

STODDARD COUNTY MEDICAL SOCIETY.

The Stoddard County Medical Society met in regular bi-monthly session in Bloomfield, on September 4th.

The visiting members were entertained at dinner by the local physicians, and the society was called to order at the Odd Fellow's Hall, at 1:30 p. m. by the Vice-President, Dr. Ed. Moore.

Members present: Drs. Ashley, Moore, Turnbaugh, Evans and Poe of Bloomfield; Drs. Vernon and Slayden of Dexter; Kerr of Dudley; and Farber of Leora. Also Drs. Sloan, D. D. S., and E. G. Kesling, D. D. S., of Bloomfield, who were invited to participate in the discussion.

Dr. Ashley reported the death of Dr. D. R. Corbin on August 10th and suitable resolutions were adopted.

Dr. Corbin was one of the most prominent members of the profession in the county. He enjoyed the confidence of the profession and the entire community.

It was largely through his efforts that the society was organized and has been kept in good working shape. He has been president of the society, was the delegate to the last meeting of the State Society and was appointed Councilor of the 23d District.

The Society recommended and endorsed Dr. T. C. Allen of Bernice to the Judicial Council for the position made vacant by the death of Dr. Corbin.

The Board of Censors reported favorable on the applications of Dr. A. D. Farber of Leora and Jno. D. Poe, of Bloomfield and they were elected members of the Society.

Dr. Ashley presented an interesting case of lack of motion of lower jaw, which was examined and discussed at length.

Dr. Slayden opened the discussion on "Early Fibroids of the Uterus," and E. G. Kesling, D. D. S., presented a paper on "Relation of Physicians and Dentists With Regard to Deposits on the Teeth."

Both subjects were discussed by all present, and every one felt that it had been a very profitable meeting.

The next meeting will be held at Dexter, on the first Wednesday in November. The entire profession of the county are earnestly requested to attend.—Geo. W. Vernon, M. D., Reporter.

ST. LOUIS COUNTY MEDICAL SOCIETY.

The St. Louis County Medical Society met at Kirkwood, August 14th.

Dr. R. W. Mills presented a specimen of ileum showing a large perforation occurring in typhoid fever. He also showed microscopic specimens of blood from a baby of one year with leukaemia.

Dr. A. E. Taussig of St. Louis read a very practical paper on "The Use and Abuse of the Microscope in General Practice."

Dr. Le Roy Grimes of Maplewood was elected to membership.

MEETING OF SEPTEMBER 11TH.

The meeting of September 11th, was held at Kirkwood. After disposal of routine business, Dr. C. S. Armstrong read a paper on "Typhoid Fever" reporting some interesting and unusual clinical manifestations. Both meetings were well attended.—R. D. MOORE, M. D., Reporter.

BOOK REVIEWS

A Manual of Obstetrics. By A. F. A. King, M. D., Professor of Obstetrics and Diseases of Women in the Medical Department of the George Washington University, Washington, D. C., and in the Medical Department of the University of Vermont, etc. Tenth edition, enlarged and thoroughly revised. 12mo., 688 pages, with 30 illustrations and three colored plates. Cloth, $2.75, net. Lea Brothers & Co., Philadelphia and New York, 1907.

A review of King's Manual of Obstetrics would indeed be superfluous; any work passing into the tenth edition has long ago had the stamp of approval set upon it. This little book has been a standard with students and practitioners for a long time, and the last edition has been brought up to date and well illustrated and will no doubt remain as popular as it has been for many years.

The Practitioner's Medical Dictionary. An Illustrated Dictionary of Medicine and Allied Subjects, Including all the Words and Phrases Generally used in Medicine, with Their Proper Pronunciation, Derivation, and Definition. By George M. Gould, A. M., M. D. With 388 Illustrations. Octavo xvi + 1043 pages. Flexible Leather, Gilt Edges, Rounded Corners, $5.00; with Thumb Index, $6.00, net. P. Blakiston's Son & Co., Publishers, 1012 Walnut St., Philadelphia.

There are many good medical dictionaries on the market. Those edited by Dr. Gould have always been looked upon as standard by the profession. This book is entirely new, and contains about all the medical words and terms that will be found in the standard medical text-books and journals. The illustrations, however, are poor and not in keeping with the excellence of the rest of the book.

The Principles and Practice of Modern Surgery. By Roswell Park, M. D., Professor of Surgery in the University of Buffalo, Buffalo, N. Y. In one very handsome imperial octavo volume of 1072 pages, with 722 engravings and 60 full-page plates in colors and monochrome. Cloth, $7.00, net; leather, $8.00, net. Lea Brothers & Co., Philadelphia and New York, 1907.

This new individual book is the successor of the Surgery by American Authors edited by Professor Park, which ran through three editions. His collaborators therein have most willingly placed their work and accompanying illustrations at his service. As Professor Park is equally at home in the surgical literature in English, German and French, the three languages to which everything in the civilized world must come for dissemination, his Modern Surgery may be trusted as an authoritative exposition of the world's most advanced views and practice at the present time.

A Compend of Materia Medica and Therapeutics. By Dr. S. O. L. Potter. P. Blakiston's Son & Co., 1012 Walnut St., Philadelphia.

Dr. Potter needs no introduction to the medical student. His writings along this line have been used for years in most medical schools and schools of pharmacy. As a general proposition the use of quiz-compends is not encouraged by teachers, but the student persists in using them, probably to his profit. Dr. Potter's little book has run into the seventh edition, the last edition being a very complete and useful little volume.

International Clinics. Vol. II. III. IV. Sixteenth Series. Edited by A. O. J. Kelly, M. D., With the Collaboration of a Large International Staff. J. B. Lippincott Co., Philadelphia, Pa.

The clinical lectures or papers published in the volumes under review are all written by eminent men and are well calcuated to increase our knowledge. As a rule the articles are well written. In volumes II and III there are remarkably well illustrated papers on the treatment of fracture by Dr. Geo. G. Ross.

Rovighi, of Bologna (Vol. II) reports some experimental researches on surgical interventions in nephritis and confirms the views expressed by others that a true and useful anastomosis forms between the peri-renal and the intra-renal decapsulation.

Lloyd (Vol. II) has a good and racy paper on Neuroses of the Stomach which is calculated to do much good. The perennial discussion of the repair of the ruptured female perineum is attended to by Dorland in a well illustrated paper. Rodman's careful work on Mammary Cancer is excellent not only because of the beautiful illustrations but because of its intrinsic merit.

Bradford's article (Vol. III), The Hyperemia Treatment of Swollen Joints, is an admirable account of the methods of Bier and Klapp. In the West too little attention has been paid to these methods.

An article on the Radical Cure of Hernia, by A. N. McGregor is like its author, sensible. Cumston discusses the clinical significance of the peritoneal adhesions.

In volume IV, there is an excellent series of papers on Genito-Urinary subjects. Arthur R. Elliot speaks of obscure Renal Hematuria, and David Wallace lectures on Vesical Tumors.

Leon Bernard (Paris) gives a very valuable account of recent work on the diseases of the adrenals. This article is of unusual value. Lilienthal gives much practical advice as to the non-operative treatment of renal and ureteral calculus colic.

The three volumes contain other lectures on medical and obstetrical subjects all from experienced workers in the field.

J. F. B.

TEXT-BOOK OF PSYCHIATRY. A Psychological Study of Insanity for Practitioners and Students. By Dr. E. Mendel, A. O. Professor in the University of Berlin. Authorized Translation. Edited and enlarged by William C. Krauss, M. D., Buffalo, N. Y., President Board of Managers Buffalo State Hospital for Insane; Medical Superintendent Providence Retreat for Insane; Neurologist to Buffalo General, Erie County, German, Emergency Hospitals, etc.; Member of the American Neurological Association. 311 Pages. Crown Octavo. Extra Cloth. $2.00 net. F. A. Davis Company, Publishers, 1914-16 Cherry Street, Philadelphia, Pa.

The translator has furnished the student of this very difficult branch of medicine with a most excellently arranged text-book, the manner of presenting the subject being one of the prominent features of the book. The idea of dividing the text into two grand divisions, general psychiatry and special psychiatry, is undoubtedly a good one, and will do away with a great deal of the confusion which always attends the efforts of the student when he attempts to make any classification of mental diseases. There is a great deal more in the book than one would suppose upon the first examination, for we find nearly every morbid condition of the mind very well covered. This, we believe, is the first edition of Professor Mendel's work to be presented to the Aemrican profession, and it will be well received by them.

EYE, EAR, NOSE AND THROAT. The Practical Medicine Series. 1907. Edited by Gustavus P. Head, M. D. Assisted by Casey A. Wood, M. D., and Albert H. Andrews, M. D. 340 Pages. Published by the Year Book Company, 40 Dearborn St., Chicago.

The volume of the Practical Medicine Series devoted to the Eye, Ear, Nose and Throat is very meritorious. It is designed for the general practitioner but is extremely useful to the specialist as a review and digest of all the important literature of his subject for the preceding year.

Of the 21 chapters devoted to the Eye, the one pertaining to new instruments and appliances seems very attractive. The illustrations are chosen with rare good judgment and enable the reader to readily grasp the inventor's idea. The chapter upon comparative ophthalmology deserves warm commendation. It is illustrated by colored plates, beautiful in execution and in effect. To a person interested in the purely scientific aspect of the question, who has not the original monographs, this chapter alone is sufficient *raisson d'etre* for the book.

The section on the Ear is subdivided anatomically, the more interesting phases of the external, middle and internal ear being considered consecutively. On the whole this section of the book is valauble but its illustrations are few and uninteresting.

In the section upon the Nose and Throat the leading subjects are paraffin prosthesis, submucous resection of the septum and the accessory sinuses. It is evident that the last word has not yet been said on any of these topics. J. W. S.

THE PRACTICE OF OBSTETRICS. By American Authors. Edited by Charles Jewett, M. D., Professor of Obstetrics in the Long Island College Hospital, Brooklyn, N. Y. In one handsome octavo volume of 786 pages, with 445 engravings in black and colors and 36 full-page colored plates. Cloth, $5.00 net; leather, $6.00 net; half morocco, $6.50 net. Lea Brothers & Co., New York and Philadelphia.

It is quite a rare occurrence in medical literature to find a work of composite authorship appearing in successive new editions. Generally the demand ceases with the first issue. Thus it must be inferred from the fact that Jewett's Practice of Obstetrics is now appearing in its third edition, that it is a well-edited work of proved quality. It is a work equally suited to the needs of the obstetrician and the student.

A TEXT-BOOK OF PHYSIOLOGICAL CHEMISTRY. For Students of Medicine and Physicians. By Charles E. Simon, M. D., Professor of Clinical Pathology in the Baltimore Medical College. New (3d) edition. In one octavo volume of 490 pages. Cloth, $3.25, net. Lea Brothers & Co., Philadelphia and New York, 1907.

Simon, in this excellent work, which now appears in its third edition, considers the chemistry of the three classes of foodstuffs, their digestion, assimilation, metabolism and excretion, and of the products of the various glands and organs. His presentation adapts the work for use as a text book, a laboratory manual, or for the office needs of the physician in active practice. The book is carefully revised to date.

A TREATISE ON THE PRACTICE OF MEDICINE. For Practitioners and Students. By Arthur R. Edwards, M. D., Professor of the Principles and Practice of Medicine and Clinical Medicine in the Northwestern University Medical School, Chicago. Octavo, 1328 pages, with 101 engravings and 19 plates. Cloth, $5.50, net; leather, $6.50, net. Lea Brothers & Co., Philadelphia and New York, 1907.

This new addition to the large number of text books on the practice of medicine, is a well rounded work from the pen of an experienced and successful teacher. It covers theory as leading up to and explaining facts, and at the same time abounds in sound practical advice. It will prove a useful work to both the practitioner and the student.

A MATERIA MEDICA FOR NURSES. By Emily A. M. Stoney. Published by W. B. Saunders Co., Philadelphia and London.

This book has passed through three editions in the last seven years, and if the present high standard of the work is maintained it will probably remain a very popular book for some time to come. The book is just what its title says it is. There is a good chapter on the treatment of poisons; apomorphine is advised to be given as an emetic in opium poisoning; we doubt if this is the proper treatment. The glossary in the back of the book is useful.

AMERICAN MEDICAL ASSOCIATION.

Next Annual Meeting at Chicago, 1908.

President: JOSEPH D. BRYANT, New York City.
President Elect: HERBERT L. BURRELL, Boston.
Secretary and Editor: GEORGE H. SIMMONS, 103 Dearborn Ave., Chicago.

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Next Annual Meeting, Springfield, May 1908.

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Chairman: T. F. LOCKWOOD, Butler. Secretary: GAIL ALLEE, Lamar.

Surgical Section.

Chairman: H. E. PEARSE, Kansas City. Secretary: P. Y. TUPPER, St. Louis.

ORATORS.

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JOHN H. DUNCAN, St. Louis.

Oration on Surgery:

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Sullivan	J. C. Kessinger	Milan	J. S. Montgomery	Milan.
Vernon	W. T. Bohannan	Nevada	T. McLemore	Nevada.
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Washington	J. A. Eaton	Belgrade	W. S. Smith	Belgrade.
Wayne	J. P. Sebastain	Patterson	R. J. Owens	Mill Spring.
Webster	H. Highfill	Marshfield	Wm. R. Beatie	Marshfield.
Worth	Arch Long	Denver	J. K. Phipps	Grant City.